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OVERSIGHT HEARING ON VETERANS' HEALTH-CARE DELIVERY IN ARIZONA

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

JULY 5, 1988
PHOENIX, AZ

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OVERSIGHT HEARING ON VETERANS' HEALTH-CARE DELIVERY IN ARIZONA

TUESDAY, JULY 5, 1988

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Phoenix, AZ.

The committee met, pursuant to notice, at 8 a.m., in the Maricopa County Board of Supervisors Auditorium, Phoenix, AZ, Hon. Dennis DeConcini, presiding.

Present: Senator DeConcini.

Also present: Congressmen Kyl and Stump.

OPENING STATEMENT OF SENATOR DeCONCINI

Senator DECONCINI. Good morning, ladies and gentlemen. I am very pleased to welcome my colleagues in the Arizona congressional delegation who are joining me here today. I will invite them to make their statements in a few moments.

Our purpose in being here is to address the critical and urgent issue of the Veterans' Administration health-care delivery system. As our time today is limited and the testimony to be heard is far too important to be constrained in any way, I only have a few brief opening remarks.

As noted in our letter of invitation, we will focus today on the issues of nursing staff shortages, vet center programs, posttraumatic stress disorder unit at the Carl T. Hayden VA Medical Center, access to nursing home care for veterans both at VA facilities and in the community, overall views on allocation of resources to VA medical centers in Arizona, and the inpatient surgery unit status at the Prescott facility. I will have much more to say about the latter as we begin testimony.

By focusing on these five areas, I do not imply that they are the only issues, nor that they are the most important issues. There are many others. I do feel that there is an immediacy and urgency in addressing these issues, not only for Arizona and her veterans, but for all veterans in this country.

It is more than possible that one of the recommendations to come out of this field hearing will be a finding of necessity for enlarged and indepth hearings in the future.

It is certain that we will not resolve these issues today, but it is a beginning. I'm hopeful that continued dialog among those of us who have the welfare of veterans as a priority will stimulate and hasten the resolution of the problems facing the VA Medical Center.

Before I extend greetings to my fellow members, the Arizona congressional delegation, I would like to welcome directors and chiefs of staff from the VA Medical Center who are with us, and the regional director.

I most specially want to thank the representatives of the veterans organizations who have taken the time to work so many, many years in this area, and consistently work with us in improving medical care.

I would also like to extend to Senator Cranston and Senator Murkowski, the chairman and ranking member of the Senate Committee on Veterans' Affairs, my sincere gratitude for approving this field hearing. Because of budget restraints we don't have many field hearings on the Veterans' Affairs Committee. Senator Cranston and his staff have been most helpful in the task of arranging for today's hearing.

I welcome to Arizona Miss Sandy Isaacson of the Senate Committee on Veterans' Affairs, a staff member there who is very capable and competent. I also want to thank Peter Doria, an intern in my office; Tim Gearan of my Washington office, who is my legislative assistant for veterans' affairs, sitting to my left; Judy Leiby, who has worked for 12 years now on veterans' issues in my office; and Avis Jackovich, who works in my Tucson office in this area. We are grateful to have these types of people with us.

We do note that both Congressman Stump and Congressman Kyl have to catch planes at noon, so we will see them leaving here around 10:30 or 10:45. This hearing will have to end at 1 o'clock because I have other commitments and have to get halfway back to Washington myself.

At this time I do want to thank the Board of Supervisors of Maricopa County for offering, at no cost to the Senate Committee on Veterans' Affairs, the facilities to this type of hearing. They have been extremely generous with their technical help and assistance.

I'll now yield to Congressman Stump, and he serves on the House Veterans' Affairs Committee, as all Arizonans know. He is a good friend of mine, and I appreciate very much having you here, Congressman Stump.

OPENING STATEMENT OF CONGRESSMAN STUMP

Mr. STUMP. Thank you, Senator.

First, let me commend you for arranging this hearing. I think it will be of benefit to all of us. I know I have some questions about the—although I have not been notified officially—closing of the inpatient surgical wing in Prescott. Because we do have to leave early, and in order to save time, I will reserve the rest of my time for some questions.

Senator DECONCINI. Congressman Kyl, we're very pleased to have you join us. We know of your tremendous interest in the veterans' areas, working on the cemetery and what have you in the first year-and-a-half, almost 2 years you have been there. Thank you for being with us.

OPENING STATEMENT OF CONGRESSMAN KYL

Mr. KYL. Thank you, Senator DeConcini, and I too would like to compliment you, not only for holding this hearing—but, for your leadership role. You and Congressman Stump ought to have that cemetery or some tree named after you because of your hard work in securing the cemetery. I personally appreciate it and I know everyone else here does as well.

I would like to note that as a member of the House Armed Services Committee, and particularly serving on the Subcommittee on Military Personnel and Compensation, I'm reminded on a weekly and sometimes daily basis of the commitment and sacrifices of those who are called upon to serve this country, and I am constantly reminded that the Congress therefore has an obligation to provide the necessary support, both for those who are currently serving and for those who have served, and it is for that reason that I am anxious to participate in this hearing this morning and again express my appreciation for your leadership in calling them.

Senator DECONCINI. Congressman, thank you very much.

We're going to move right ahead now. Our first witness will be Richard Miller, the Director of the VA Department of Medicine and Surgery, Region 7.

Mr. Miller, thank you for being with us today. We would ask that you summarize you statement, if you will. Your full statement will appear in the record and you may proceed, and if you have any assistants or anybody you would like to have with you, please do not hesitate to ask them to join you.

And if you could introduce them for the record, please.

STATEMENT OF RICHARD P. MILLER, DIRECTOR, SOUTHWESTERN REGION, VA DEPARTMENT OF MEDICINE AND SURGERY, ACCOMPANIED BY RICHARD ROBINSON, ASSOCIATE DEPUTY REGIONAL DIRECTOR

Mr. MILLER. Thank you, Senator. I have with me Mr. Richard Robinson, who is my Associate Deputy Regional Director at Grand Prairie for Region 7.

I want to thank you for the opportunity to appear before this committee and discuss the access to the veterans' health care of the Arizona veterans. I understand that my entire statement is to be made available to you and will appear in the record; therefore I would like to emphasize some areas that I think are important.

As you know, the southwestern region is the VA's newest region, established in June 1985. It encompasses six states which Arizona is one of them.

In the State of Arizona we have approximately 490,000 veterans. The operating budget of the three facilities in the State of Arizona is $148 million, approximately.

They employ 2,900 at VA with 25,000 inpatients treated annually, and approximately 387,000 outpatients treated annually.

On the subject of the allocation of health-care resources for VA facilities in Arizona, the resource allocation model, our RAM, is utilized to allocate recurring funding to VA facilities and it takes into account workloads, diagnoses, medical procedures, and severity of illness.

In addition, inflationary costs are provided in determining the medical center's budget. Additional funding has also been provided by the medical district initiated planning process, and in 1987, the fiscal year which is the first year of MEDIPP funding, the Phoenix VAMC received $523,000 to implement three initiatives.

In fiscal year 1988, Phoenix and Tucson VAMC's received $695,000 for three separate initiatives.

Since fiscal year 1986, $4.8 million has been allocated to the Arizona VAMC's for equipment. Another $5 million was provided for nonrecurring maintenance and repair projects, and in addition there has been 16 construction projects funded for $27,427,000.

Regarding the availability of surgical services for veterans residing in the Prescott area, the VA Department of Medicine and Surgery and the southwestern region are concerned about the access of quality care for all its veterans. All of the health-care needs of our veterans, from acute to extended care and outpatient care, must be considered in the light of the aging of our veteran population and available resources.

As the committee is aware, a recommendation was made to and then accepted by the VA Administrator through the 1988 MEDIPP process to close the inpatient surgical program at VAMC Prescott.

Although the inpatient surgical program actually closed prior to this decision as a result of key staff losses, since that time the Prescott VAMC surgical program has been essentially limited to outpatient services only.

However, the issue of resuming the inpatient program has been addressed by several VA review mechanisms, including a formal task force conducted at the regional level.

I now understand that the Chief Medical Director has reviewed the various reports resulting from this re-review of the original medical proposal, and I have been informed that he has decided to reconfirm the original agency decision to close the inpatient program, and the Department will now move to implement the various actions to fulfill all the actions associated with this decision.

I and my staff will be working diligently with our colleagues at the Phoenix, Tucson, and Prescott VAMC's to assure that the veterans served by Prescott will receive quality programs in a timely manner at a cost-efficient and effective level.

Mr. Bourne, Mr. Boyd, Mr. Estrada, and the medical district and other offices have assured me of their utmost support and cooperation in achieving complete success in this new effort.

A short statement about the recruitment and retention of nursing staff; we are concerned with the national shortage of nursing staff.

The current vacancy rate for RN's at these facilities is consistent with national rates, and the turnover in all categories of nursing is of particular concern.

Recruitment and retention activities are ongoing at each facility to address issues within their control. Special entry pay rates for RN's have been approved at all three facilities. Significant tuition support funds have also been provided to each, and the newly approved Saturday premium pay should also assist in recruitment and retention.

In all candidates, based on the projections of nurses being trained nationally, we do not expect the existing situation concerning the availability of nurses to change in the near future.

In regard to the access of Arizona veterans to nursing home care, the VA has a 120-bed VA nursing home care unit at the Phoenix VAMC and a 41-bed VA nursing home care unit at the Tucson hospital.

Both of these are filled. We are presently constructing a 60-bed VA nursing home care unit at the Prescott VA hospital at a cost of some $5.4 million, which should be completed in May of 1989.

We will also be building a 120-bed VA nursing home care unit at the Tucson VAMC, and the contract for this unit at Tucson should be awarded this year at an estimated completion of August 1990.

In addition, three Arizona hospitals are funded $7.6 million to place veterans in community nursing homes at VA expense. Through June 1988, there has been a combined average daily census of 307 veterans in community nursing homes.

This concludes my statement and I'll be pleased to respond to any questions you may have. Thank you.

[The prepared statement of Mr. Miller appears on p. 63.]

Senator DECONCINI. Director Miller, thank you very much. My apologies for the witness list having your first name incorrect. We know who you are.

I also want to make reference to Mr. Del Berry, who is also on our staff now. We thank him for his expertise and the help that he's given here.

Mr. Miller, I thank you for traveling this far to be with us. It's an important period of time for Arizona and its veterans, particularly in the northern part of the State.

I must first emphasize my surprise and complete dissatisfaction with the decision reached and communicated to Senator Cranston and myself a few days ago in regard to the Prescott VA Medical Center inpatient surgery unit.

I'm sure that many here today will address this issue as we proceed here. Congressman Stump and I have repeatedly communicated to the Department of Medicine and Surgery in the VA Central Office our grave concern about what is happening at the Prescott Medical Center.

After reading Dr. Gronvall's letter, I'm convinced that Congress has a responsibility to take some action in this matter; specifically, I'm not at all convinced that the much-touted MEDIPP process has worked in this particular instance, nor am I convinced that the review allegedly done on this matter was as wide ranging and comprehensive as was represented to me.

Information submitted to me from VA sources, from veterans organizations and individuals are in contradiction to the DM&S statement of findings, and I therefore intend to pose a number of questions to the Prescott—on the Prescott matter.

I am disappointed that the DM&S chose this time to announce their action, as I am afraid that other vital concerns we intended to address today may be overshadowed by the urgency of the Prescott situation.

I'm also disappointed that the VA Central Office did not see fit to have a dialog with this Senator or other members of the Arizona delegation prior to such a public announcement.

It is curious that this particular time was chosen, as a review and report had been delayed for months and months for some reasons unknown to me. I can see no adequate or acceptable rationale for the disclosure at this point in time.

As a member of the Senate Committee on Veterans' Affairs, and on the Appropriations Committee, I work closely with the Chief Medical Director on many veteran medical issues. Dr. Gronvall has known throughout our relationship that I've always been there to fight for these desperately needed funds to maintain accessible, quality health care to veterans, and, quite frankly, I think the VA's handling of this affair will greatly alter our working relationship and I am disappointed in that.

My first question: As Regional Director, what was your role, both generally and specifically, in this particular decision? Were you or any members of your staff on the task force charged with reviewing the closure of the surgical unit in Prescott?

Mr. MILLER. Yes, sir; our MEDIPP process, as you are aware, is a grassroots planning program with the focus and the nucleus of the planning at the local level, and in 1983 the District Planning Board reviewed the mission requirements of all the facilities in Medical District 24 in light of the demands and planning horizons that were being presented to us relative to the expanding need of extended care and long-term care needs.

In line with this mission statement the District Planning Board, chaired by a—chaired by the chairman of the Planning Board, the chief of staff counsel and three surgeons reviewed the data relative to all the facilities and the facilities involved in the Prescott area, of Tucson and of Phoenix, and presented through the MEDIPP plan a proposal for a change in the mission of Prescott which included the reduction of inpatient surgery and the expansion of ambulatory surgery and the provisions for extended care facilities that were sorely needed in this area.

That review was presented as a recommendation through my office. After review by my office, I then forwarded it to the Chief Medical Director, and which was then forwarded on to the administrator.

Senator DECONCINI. So you approved it.

Mr. MILLER. Yes, I did.

Senator DECONCINI. As part of your decision process.

Mr. MILLER. Yes, sir, I did.

Senator DECONCINI. And what sources and evidence were collected or utilized to determine that veteran access to surgery care has not been diminished?

Mr. MILLER. We reviewed all the demographic data. We've reviewed the historical pattern of the types of surgery, activities of surgery, the complexities of surgeries and frequencies of surgeries in the Prescott area.

At the same time we have reviewed data that involved care facilities in this area under representative extended care facilities, and that's one reason why we're building the nursing care home

unit in Prescott and the nursing home care unit in Tucson, and also replacing the entire domiciliary facility in Prescott.

Senator DECONCINI. Was the fact that the nursing—new nursing care facility there have some bearing on this decision?

Mr. MILLER. No, sir, it did not.

Senator DECONCINI. I would hope not, because I would never have supported that had that been the case.

Mr. MILLER. No, sir, it did not. That was cognizant of all the data we demonstrated that we knew we would need various forms of extended care.

Senator DECONCINI. In regard to the decline of surgical workload in Prescott, or inadequate surgical workload to maintain "quality surgery," as cited in Dr. Gronvall's letter, I would like some clarification. Maybe you can help me. I intend to ask the doctor also.

It is common knowledge that the VA medical centers do not offer a complete range of specialties such as pediatrics, limited ob-gyn, et cetera, and that certain specialties are available only at large centers, I refer to dialysis and cardiac bypass and rheumatology, et cetera.

Thus, I would prefer not to compare apples and oranges. As we all know, the Prescott has never had such capabilities, and I would hope that there is no implication that the highest quality care possible is not delivered in smaller VA centers which do not have all medical specialties.

Please assist the committee by defining what you mean by the phrase—an adequate surgical workload.

Mr. MILLER. Adequate surgical workload—and I'm not a physician, Senator——

Senator DECONCINI. I understand.

Mr. MILLER [continuing]. But adequate surgical workload is a workload of the volume and complexity and frequency that would enable the maintaining of the surgical skills necessary to maintain the quality of the surgical program. We do have a number of facilities in the Department that do not have surgery.

Senator DECONCINI. Do you know that the Prescott could not deliver adequate surgical processes there?

Mr. MILLER. From the data that was reviewed, and reviewed by health-care professionals including surgeons, it was their opinion and determination that the volume and frequency and complexity of the surgery being performed there, with the decrease in the amount of surgery over the last decade, would not be conducive to recruiting and retaining qualified surgeons and maintaining the competency and skills of surgeons there.

Senator DECONCINI. Well, Mr. Miller, surgical procedures at Prescott were over 2,000 in 1984, over 1,600 in 1985, and 659 in 1986, with closure of the surgery wing in June of 1986, so half the year we had 659.

Where did the VA get the figure of only 600 surgeries in Prescott for 1984 and 1985, as cited by Tom Harvey, the Deputy VA Administrator? How do you answer this discrepancy?

Mr. MILLER. When we reviewed all of the data through the district and then the special re-review, we took all reports of surgical activities from the Prescott area, went to the hospital, reviewed

their logs; and since 1983 the total of postsurgical discharges in Prescott PSA has dropped from 1,055 in 1983 down to 720 in 1987.

Now, a majority of those are an ambulatory care surgery activity. The health-care system, certainly in the last few number of years, has made a dramatic change to an emphasis of performing ambulatory surgery that could be performed, so our data indicates that the inpatient surgical activity in Prescott had declined, and the ambulatory surgery activity in Prescott has almost doubled in that time.

Senator DECONCINI. Did you have available any surveys taken by veterans organizations to the contrary?

I think there's a problem here, because there's a great discrepancy of 2,000 in 1984, 1,600 in 1985, and the indication here that there was only 600 surgeries in 1984 and 1985.

Mr. MILLER. That's correct from the data we have, Senator. If there are other datas available——

Senator DECONCINI. Well, did you have other data? Did you have other data and did you attempt to find out why there was such a discrepancy?

Mr. MILLER. Because the data we had was from the data of the Department of Surgery, and data that was inputted from our medical records and from the facility itself.

Senator DECONCINI. I'm going to see, Mr. Miller, that you have the data that I have; and I can't verify it, but I would certainly like to see a response to how you answer this huge discrepancy.

Further, do you know if the DM&S has included beneficiary travel costs in their cost analysis of the Prescott surgery issue?

Mr. MILLER. I cannot answer that, Senator, but I will get that for you.

Senator DECONCINI. Would you, please? I'd appreciate it.

Mr. MILLER. Certainly.

Senator DECONCINI. Moving on to one other matter before I yield here, who is responsible for the recently enacted 45-day limitation on community nursing home contracts?

Mr. MILLER. There is a—if I understand the question correctly, there is a limit of placing nonservice-connected veterans into community nursing homes at VA expense.

Senator DECONCINI. Yes.

Mr. MILLER. And that 6 months is for the time to make preparations for opening placement and planning, and the Chief Medical Director has extended—there is another 45 days given beyond those 6 months in the event that the planning could not have been accomplished in that 6 months; yes, sir.

Senator DECONCINI. It's been changed to 6 months. I apologize.

Mr. MILLER. In certain circumstances.

Senator DECONCINI. Who makes that—who is responsible for that?

Mr. MILLER. That's a local decision.

Senator DECONCINI. It is?

Mr. MILLER. Yes, sir.

Senator DECONCINI. So you don't know the rationale for this decision, given the fact that Congress has consistently been willing to allocate additional funds?

Mr. MILLER. I can't answer that, sir.

Senator DECONCINI. OK. Mr. Miller, Phoenix is consistently first or second in growth of urban areas of the United States. Mohave County is the fastest growing county in the United States, with Yavapai County ranking a close second.

What are you, as Director of this medical region, doing to advocate allocations of resources to this area of urgent and ever-increasing needs; and how much, if anything, is being done to advocate allocation of resources based on these seasonal uses here and the tremendous growth?

Mr. MILLER. Our resource allocation methodology, as I've stated, is the method of distributing resources to the whole system in the Veterans' Administration hospitals, and that's based on workload, severity of illness, and other factors that I mentioned; and as evidenced by the position of the Phoenix VA Medical Center in that process over the last number of years, they have been very successful in that process.

In addition, through the medical planning process, relative to dollars available for that, as I mentioned I have made judgments that a number of those medical programs would come to Phoenix to meet the need.

Senator DECONCINI. When you offer those judgment recommendations, and they're turned down, what is your road to appeal that judgment? Is there any?

Mr. MILLER. Not after all of the presentation goes forward, Senator.

Senator DECONCINI. The Washington Central Office is final?

Mr. MILLER. Yes, sir.

Senator DECONCINI. One last question: Is it correct that all testimony by VA personnel presented here today has been reviewed and edited by the Veterans' Administration?

Mr. MILLER. Yes, sir; we are required by Agency requirement to present any testimony to them.

Senator DECONCINI. And you edited it?

Mr. MILLER. No, sir, I did not edit it.

Senator DECONCINI. Who does?

Mr. MILLER. I'm not aware of any other than my own testimony..

Senator DECONCINI. And you don't know if everybody who submitted testimony who works for the VA had to have it reviewed and edited?

Mr. MILLER. Yes, sir; everyone did have to have it reviewed.

Senator DECONCINI. They did have?

Mr. MILLER. Yes, sir; I do know that. Yes, sir.

Senator DECONCINI. I'm rather curious why that is necessary. Do you know why that's necessary?

Mr. MILLER. That's a requirement of our Agency, sir.

Senator DECONCINI. Because I think it's difficult to have oversight hearings that are candid when everybody else has to toe the line and we have statements reviewed.

I think there is total dedication in the Veterans' Administration of their field people and their operation people, and for that reason I just wonder why the freedom of expression is something that the VA feels that it has to get involved in and censor people's information that they would supply to the funding authority for the VA.

Do you want any editing of anybody in your region or is that done by Washington?

Mr. MILLER. My staff helps in the sense of improvements for statements relative to English; and if there are any errors in information of data, then we offer that.

Senator DECONCINI. So the hospital directors here in Arizona send their statements to you?

Mr. MILLER. Yes, sir; and then we forward them.

Senator DECONCINI. And you forward them to Washington?

Mr. MILLER. Yes, sir.

Senator DECONCINI. And so major editing is done in Washington——

Mr. MILLER. That is correct.

Senator DECONCINI [continuing]. But, the accuracy for figures and punctuation and spelling is checked by your office.

Mr. MILLER. Actually, it goes to the portion of my office directly in Washington.

Senator DECONCINI. In any case, we have not received your statement. It may be here. We would appreciate having it, edited or unedited; whatever way you can give it to us.

I yield to Congressman Stump.

Mr. STUMP. Thank you, Senator.

Mr. Miller, first off, thank you for taking the time to come down here and be with us today. Like Senator DeConcini, I have some problem—and maybe it goes back to the base that we're using—there's obviously a large discrepancy in the number of patients cared for between what you have and what we have here, and I'll be going back and looking at it.

Let me go back and try to set the record straight just a little bit. If I understand it, you made the decision as Regional Medical Director on your level because of the figures of the decreased service at the hospital, is that right? Or the number of patients, rather.

Mr. MILLER. No, sir; because of the recommendation through our planning process from the medical district relative to meeting the extended care needs of our aging veterans.

Mr. STUMP. That had nothing to do within the surgical wing?

Mr. MILLER. And the change in emphasis on ambulatory surgery and the decrease in the number of inpatient surgeries, together with the history of Prescott and the inability to recruit and retain surgeons.

Mr. STUMP. If we could recruit and retain surgeons before we spent almost a million dollars to improve that wing, it's hard for me to understand the logic to say, "Now we can't hold surgeons," because we have a brand new million-dollar facility there.

Mr. MILLER. Well, my information—and this was prior to the beginning of region 7—was that since about 1982 there had been some turnover in key surgeons. In fact, prior to the completion of that $800,000 construction on the fifth floor, we had lost, I believe, the urologist.

And that construction on the fifth floor, approximately $800,000 was done to maintain present patient treatment standards through our Joint Commission on Accreditation oversight activities, and we started to request the construction for that modernization back in

1980 through certain forces. We did not have the money until about 1984.

But included in that construction was a relocation to develop, adjacent to the OR, a recovery room, some upgrade of x-ray equipment, and that theater is still presently available and is being used for ambulatory surgery.

We have had a tremendous emphasis in the health-care industry in emphasizing ambulatory surgery, which is in the best interest of the patient as well as a cost-effective modality.

Mr. STUMP. Could some of these doctors have left because the word was out that the surgical wing was going to be closed even before we completed construction, or reconstruction?

Mr. MILLER. I can't answer that.

Mr. STUMP. I don't understand, with the growth of the veteran growth in Arizona, and particularly in the Prescott area probably outgrowing any other area right now as far as veterans are concerned, the logic for closing this wing down after spending, as you said, $800,000, whatever it was; saying that, "Well, we don't have doctors."

Surely there are enough young doctors who would be willing to come to a veterans hospital in Prescott to fulfill the need of the Veterans' Administration there if they were asked.

If they did it before, I can't understand now, with a brand new center to work with, they couldn't recruit doctors.

Mr. MILLER. Certainly recruitment and retention of physicians involves facilities available. It also involves the complexity and diversity and volume of surgical procedures to maintain those qualities desired; and the present surgical procedures being performed at Prescott, which includes dramatic doubling of the ambulatory surgery activities as well as the inpatient surgical activities being performed at Phoenix and minor numbers at Tucson, are actually the same number—approximately the same numbers—of surgeries that had been performed at Prescott for almost a decade.

Mr. STUMP. Well, let me say once again that I agree with Senator DeConcini that we do have a problem with how we arrived at these numbers of patients, and somebody has been given different information than we have.

Mr. MILLER. We would be glad to take a look at any——

Mr. STUMP. I really—I am very interested, because I think there is a great need up there.

The distance—that area of the State that the Prescott hospital serves, it would make much more sense it we could retain doctors there and conduct that surgery there at that institution without brining them all the way down to Phoenix.

I thank you, and in the interest of time I won't——

Senator DECONCINI. Congressman Kyl, do you have any questions of this witness?

Mr. KYL. I'd like to switch gears just a little bit.

I think you can tell from the questions and from this hearing that we are all very concerned about the growth in our veterans population and the needs that that growth is going to present to you as a Director of the region.

On a specific note, we have been very concerned about the need to retain and to recruit nurses, and, as a result, Congress respond-

ed with Public Law 100-322. As long as you're here, I wanted to take advantage of the opportunity to ask you, as Director of region 7, what efforts you are planning to take to implement that program, specifically with respect to Arizona.

Mr. MILLER. The implementing policy decisions for all the requirements in the public law have not been issued yet but I can speak if you are asking for my personal opinion, and until such time I won't be able to answer that relative to the direction of the policy setting of the Department of Medicine and Surgery, Congressman; but certainly, as I mentioned in my opening remarks, the Saturday premium pay would be of significant benefit, the tuition, the bonus portions of recruiting and retention in that bill certainly would be advantageous, I believe personally, in my own opinion.

As I mentioned in my statement we are already taking action relative to those things under the control—in the control or span of the local hospital director of reviewing the staffing, reviewing the shifts.

We have provided, from Central Office, additional funds for premium pay and for educational supplement and those types of things.

Mr. KYL. I'm sure we all hope that those plans can be drawn up as quickly as possible and I'll just leave you with this idea, and that is that the growth here, as Senator DeConcini and Congressman Stump have both said, is so rapid in comparison to other parts of the country, that I hope that in evaluating the commitment of resources of Arizona to all of the facilities here that you would try to be ahead of the curve; that you wouldn't wait for the statistics to come in 3 or 4 years later and figure out that 3 years ago there was a tremendous need that maybe you should have anticipated before it came, and certainly be prepared to deal with it at the time that it came rather than perhaps waiting 3 or 4 years to develop the statistics to show that, "There sure was a problem back then, and now we're going to start doing something about it."

I'm not suggesting that that's what you have been doing, but certainly, with this tremendous growth, we need to be right on top of it, with the initiatives that you have recognized are needed because of the unique growth here in Arizona.

Mr. MILLER. Yes, sir; in fact, I can assure you that we are every day looking at planning documents and horizons that reflect that, and I'm very sensitive to that because of the six States that I have in the southwestern region, and a number of them are experiencing tremendous growth.

Mr. KYL. Thank you.

Senator DECONCINI. Thank you, Congressman Kyl.

Mr. Miller, I won't belabor this much longer. I just want to put you and the VA on notice that this Senator is first going to ask your support to reverse that decision and supply you whatever information we can that would give you the professional capacity to do so, but this Senator is going to do everything he possibly can to see that that surgical wing is reopened.

I happened to be involved in getting the $800,000 for that and it took us several years to do it, and then to have it implemented and closed under these reasons that are given, to me, is a most unwise

decision; and I at first plead with you to review this and see if you can help us in this region—which is your responsibility—to justify opening it, and if we can't win that way I'll try whatever other means I have.

And I want to thank you for being here with us today, and thank you, Mr. Roberts.

Mr. MILLER. I understand, Senator, and we would be delighted to look at any information you have.

Senator DECONCINI. Thank you.

Mr. MILLER. And I apologize for my testimony not getting to the committee.

Senator DECONCINI. That's all right. We'll include it in the record.

Mr. MILLER. It was forwarded to Washington early last week.

Senator DECONCINI. We have it there. Thank you.

We'll now have our first panel, which will be Ray Bourne, Director of the VA Medical Center here in Phoenix; Jerry Boyd, Director of the VA Medical Center in Tucson; and Alfonso Estrada, Jr., Director of the VA Medical Center in Prescott.

Gentlemen, if you'd come up, and your full statements will be inserted in the record, and if you would summarize those for us—who wants to start off?

Mr. Estrada, you're right there on the cutting edge.

STATEMENT OF ALFONSO ESTRADA, JR., DIRECTOR, PRESCOTT VA MEDICAL CENTER

Mr. ESTRADA. Mr. Chairman, Congressman Stump, Congressman Kyl, I'm honored to be here representing Prescott VA Medical Center for this distinguished committee.

I have learned since my recent testimony was submitted to this committee you have been informed of the Chief Medical Director's decision to reconfirm the original decision of not reopening the surgery at Prescott Va Medical Center.

I would like to just remind the committee, I have just been appointed the Director at the VA Medical Center in Prescott and therefore do not have firsthand knowledge of the issues regarding access to health care for veterans in the State of Arizona.

My staff has compiled some information regarding the five specific areas addressed in your letter, and that information is included as part of my testimony.

I would like to assure this committee that I'm committed, as I have been in the past, to our mission of providing high quality care to all of our eligible veterans in a timely manner.

I will work very closely with Mr. Ray Bourne, the Director of Phoenix VA Medical Center, and with Mr. Jerry Boyd, Director of Tucson VA Medical Center, to address and resolve any problems that might exist or that might arise in the future regarding the provision of medical, psychiatric or surgical services to our veterans in Arizona.

I'm impressed with the construction that is ongoing, such as the 60-bed nursing home care unit, and the soon-to-start construction of a 208-bed domiciliary. Other construction projects are planned for upgrading of existing buildings for the future. These projects

should go a long way toward helping us meet the needs of our aging veteran population.

Again, I would like to thank you for inviting me today. If there is any additional information that any member of this committee needs regarding the Prescott Medical Center, I will make every effort to provide it for the record.

Mr. Chairman, this concludes my oral statement.

[The prepared statement of Mr. Estrada appears on p. 73.]

Senator DECONCINI. Mr. Bourne.

STATEMENT OF RAY L. BOURNE, DIRECTOR, PHOENIX VA MEDICAL CENTER

Mr. BOURNE. Thank you, Senator.

Gentlemen, it's an honor to be here this morning and to have the opportunity to speak on health issues affecting veterans' care in the State of Arizona.

I have responded to the specific questions you listed in your letter in my testimony, and I would like to depart a little bit from that and recognize that only the foolhardy would address the future, but that's where I would like to take my statements today.

It's apparent to some of us who have been studying what's happening in the past, and what's happening currently, where we're going in the years immediately ahead.

One, we are now on the leading edge of a huge demand for medical services. Our veterans—this demand is driven by two factors: Our veterans of World War II are reaching that age where their health is failing. This condition will continue to be the case well into the next century, by which time the Korean veterans and the Vietnam veterans will have reached the age of declining health.

Second is the permanent growth of central Arizona. It is predicted by the year 2000 we will have more than 4 million residents in Maricopa County alone.

An added concern is the winter visitors who continue the cyclic demand for care. To date we have met that demand for service by increasing the use of ambulatory care.

We will increase our ambulatory visits by more than 30,000 visits this year beyond the 160,000 visits rendered last year; but I caution, there are limits on the use of outpatient care.

At some point, those who can be well served in an outpatient mode will require inpatient services. To this end, we have in the planning process a proper sizing of the Carl T. Hayden Medical Center to give veterans access to the level of care they require and deserve.

As in all planning processes, we must be vigilant to pursue the plan in a vigorous fashion to assure that it becomes a reality.

To that end we have sought and received considerable help from various people with regard to increasing the land available for health care. That land is desperately needed. It's the key to the further sizing of the Carl T. Hayden Medical Center, and I understand that that subject is being addressed in Congress at this time; and I would like to again make a plea that that's the leading act, if you will, of many to follow, if we are to meet the health-care needs of the veterans in this central part of Arizona.

I would be pleased to answer any questions that I might be able to do.

[The prepared statement of Mr. Bourne appears on p. 76.]

Senator DECONCINI. Mr. Bourne, thank you very much. I just want the record to show that it has been a tremendous advantage having you there as long as you have, and I'm sure that's going to be the case with our new directors.

You have been of tremendous assistance to the Arizona delegation, traveling to Washington, explaining the needs in the future as you talk about, willing to advocate with us in behalf—toward the VA Central Office for different needs at the Phoenix VA Medical Center. I thank you for that, because I realize it's a lot easier to sit back sometimes and let others above you make all those decisions.

I know the other two members that are with you here, our directors, are relatively new in Arizona, but we've got an example with Mr. Bourne that is just outstanding from the standpoint of a representative of the veterans' groups to work with, and it's just tremendous.

And Mr. Boyd, you are off to a great start down there in Tucson. We thank you for the leadership that you are demonstrating down there, and I'm not just blowing air at you; I'm telling you how helpful it is to us to be able to have administrators that are willing to share what their needs are. Even if they happen to be a lower priority in Washington, some of us can have an effect on moving them up on that priority list and we need to have your input, so you may proceed with your summary, Mr. Boyd.

STATEMENT OF JERRY B. BOYD, DIRECTOR, TUCSON VA MEDICAL CENTER

Mr. BOYD. Thank you very much, Senator.

Members of the committee, I am pleased to have the opportunity to appear before this committee today for the purpose of reporting to you on the access of Arizona veterans and Veterans' Administration health care.

I will comment first on the improvement in retention of nurses and adequacy of staffing levels. Since being employed by the Veterans' Administration Department of Medicine and Surgery approximately 18 years ago, the Nation's health-care delivery system, both in the public and private sector, had experienced a serious nursing shortage at approximately 5-year intervals.

Recruitment and retention of nurses at the Tucson Medical Center has become increasingly more difficult. Our registered nurse turnover rate in 1985 was 17 percent; in 1986, 20 percent; and in 1987, 26 percent.

New graduates and medical/surgical nurses do apply for positions with us. However, the experienced critical care nurses are very difficult to recruit.

In light of the nursing shortage, however, the quality of the care delivered at the Tucson VA Medical Center is excellent. More flexibility in pay and benefits should be provided to local management to successfully compete for the available nurses in the community.

The laws of supply and demand are currently controlling nursing recruitment and retention. We are using every option available at

the Tucson VAMC to maintain a competent and adequate nursing staff to meet the needs of our veteran patients, and to insure that the highest level of quality care is provided.

Second, I would like to comment on the availability and quality of counseling and psychiatric services for Vietnam veterans through vets in Arizona.

During the past several years there has been a concerted effort to link with that center's staff to one of the main professions within the VA Medical Center, such as social work or psychiatry.

The Tucson Vet Center staff itself has a good mixture of professional training. The Vet Center offers flexible office hours. For veterans who do not live close to Tucson there are contract services available with agencies in Casa Grande, Yuma, and Noagles.

Close ties have been established between the Vet Center and the Medical Center. The homeless chronically mentally ill program and the alcohol treatment units are two VA programs that have a high Vietnam veteran representation.

Of the 856 homeless veterans seen during the past year, 397, or 46 percent, were Vietnam-era veterans. Over 50 percent of these veterans had combat experience, and over 50 percent of the alcohol treatment unit patients are Vietnam-era veterans.

Last, I would like to comment on the access of Arizona veterans to nursing home care, either at VA facilities or at VA expense.

The Tucson nursing home care unit is a 41-bed unit consisting of a majority of total care patients. Because of the complex level of care provided to nursing home care unit patients, there's a low turnover rate in the unit.

A new 120-bed nursing home care unit has been approved and funded to replace the current facility, with groundbreaking due in the fall of this year.

There's been a marked increase in demand for community nursing home placement services over the past decade. Tucson VA contracts with 11 nursing homes in the Metropolitan Tucson area and eight rural nursing homes.

The quality of care provided by the nursing homes is of a high level. The contract nursing home program has expanded 100 percent in the past 8 years.

That concludes my statement, Mr. Chairman. I would be pleased to answer any question you or members of the panel have.

[The prepared statement of Mr. Boyd appears on p. 80.]

Senator DECONCINI. Thank you, Mr. Boyd, very much.

Mr. Estrada, knowing that you have just come to the medical center, I would like to ask you if you have had a change to review the problem there that deals with the surgical—closing of the inpatient surgical capacity.

Mr. ESTRADA. Mr. Chairman, I have—being approximately 2 weeks at the center, I have read the reports that were prepared by special task forces assigned by the Regional Director and the Chief Medical Director. I also have discussed some of these issues with some of the staff. It's a very emotional issue, I understand.

For me to speculate and to sit in judgment of the decisions that were made, I think, would be inappropriate. I would like just to say that whatever course of action is taken, my responsibility and commitment is to make sure that the veterans do not suffer from that

decision, in that we will provide them with whatever services they're entitled to.

Senator DECONCINI. Don't you think it's a good chance that veterans will suffer if they have to drive all the way to Tucson and Phoenix for surgery that could be performed there when $800,000 had been spent to upgrade that surgery unit?

Isn't there a good chance that there's going to be some suffering from veterans to have to do that?

Mr. ESTRADA. Yes, sir, I believe that there could always be a chance of suffering under circumstances like that.

Senator DECONCINI. I would only ask, Mr. Estrada, that you would take some time to review this. I will ask you some questions.

I'm not trying to put you in an embarrassing situation, but I need you honest opinion to whether or not the emotion can be separated, and what we can do is provide something, whether it's 600 or 500 surgical units or 2,000—that we need to do something, and I would ask that when you have time, that we communicate again through our staffs or personally as to what your view is.

I'm hopeful that you will concur with your advisors that I've talked to at the Prescott Medical Center who feel it's a very bad decision, and I'll leave that to your judgment.

Mr. Bourne, as I understand it, veterans who may be treated for speciality medical problems often are referred from Phoenix or Prescott to Tucson for cardiology, rheumatology, with prescriptions being written by doctors at that facility.

Why do these veterans then encounter so many problems in having the prescriptions filled back in Phoenix? Can they not be verified through the computer system now in use and billed to approprite accounts?

Mr. BOURNE. No, sir, we cannot verify it through the use of computer systems. The individuals who are receiving care at the Tuscon hospital are being prescribed by Tucson physicians and they should be followed by those physicians. They should be sure they get their medicine at that facility to make sure that that medicine is that which has been prescribed.

Senator DECONCINI. Well, does it make sense for someone in Phoenix or Prescott to have to go to Tucson for the surgery and then have to go back there just to pick up the medicine? Why couldn't they pick up the medicine—why couldn't the prescription be transferred from Tucson to Phoenix and then——

Mr. BOURNE. They could. They could mail it out. They could get it mailed out or they could pick it up while they're still in Tucson.

Senator DECONCINI. Yes, but if they've gone back and they need to refill it, from what I understand they have to go back down to Tucson now.

Mr. BOURNE. Not in all cases. In some instances, where the drugs are specialty drugs, that's the case. We transferred the—we don't have open heart surgery at our hospital, nor neurosurgery. Patients required that modality of care we do transfer to the Tucson facility.

Senator DECONCINI. Mr. Boyd, along that line is there any problem with getting the doctors there to—when they known somebody lives in Phoenix or Prescott and might have to have a prescription

refilled, that they could not get it refilled in the Phoenix center than going to Tucson?

Mr. BOYD. Senator, our pharmacy budget for the past fiscal year exceeded $4 million in Tucson, and we have a very active pharmacy program there and an active mail-out program.

It is a fact, as a matter of fact, for our outpatients, followup care, more than 75 percent of our prescriptions are mailed to the veterans and less than 25 percent of those prescriptions are actually picked up, or that requires the veteran to come in and pick up the medication.

Senator DECONCINI. So it could be mailed then from Tucson to Phoenix or Prescott.

Mr. BOYD. And they are mailed, yes, sir.

Senator DECONCINI. Thay are mailed. So it may be not realizing that that's available to the veteran?

Mr. BOYD. Yes, it very often is a communication problem, where the veteran doesn't realize it. We haven't maybe—haven't done as good a job as we should have of informing the veteran.

Senator DECONCINI. That's a fair answer, because I don't know whether or not they have tried and been declined. What I've been told is that they're told they have to go back to Tucson to get it, and maybe they haven't asked for it. We certainly will give you that information.

Mr. Bourne, are you aware that there's allegation that some social workers at the Phoenix Center have been known to counsel spouses to divorce veterans for two purposes; to establish indigent eligibility for County/State nursing home care, and to protect the merger assets of the spouses?

Mr. BOURNE. No, sir; I'm not aware of that.

Senator DECONCINI. That has come to my attention and I cannot verify it.

Mr. Boyd, at the same time you look over the Tucson center, many problems have been identified that—with facilities by the Central Office. While I realize that you have had a relatively short time to deal with some of these problems, I would like you to comment on several that area, in my opinion, very vital to the quality care for our veterans.

No. 1, the American Legion survey, which I mentioned to Mr. Miller, cites a severe lack of available ICU beds, as well as delays in surgery, cancellation problems, which existed prior to your service as the Tucson Director.

What have you done to address these problems, and has it improved at all; and lastly, what are you going to do when more and more from Prescott come down for these type of surgeries?

Mr. BOYD. Well, Senator, in the 11 months that I've been at Tuscon, I would like to acknowledge the support we have received from the Regional Director, from Mr. Miller.

We have been funded for a couple initiatives at Tucson that has resolved tremendously, I think, that problem. We have—at the time I got there our renal transplant unit was closed. Those beds have been opened back up.

We were funded from region 7 for a six-bed step down unit, which made six more unit beds available to us that had not been made available to us in the past.

So with the addition of the renal transplant unit reopening, the step down unit reopening, and some increased staffing in critical areas to closely monitor our critically ill patients, we have not placed a veteran in the community since my arrival in Tucson almost 11 months ago.

Senator DECONCINI. So you foresee no delays by the fact that surgeries are being referred to your inpatient from the Prescott inpatient surgery referral? You can handle all of those without any delay?

Mr. BOYD. We have been handling them to date, yes, sir.

Senator DECONCINI. Without any delays.

Mr. BOYD. Without delays.

Senator DECONCINI. And is that true, Mr. Bourne, with Phoenix?

Mr. BOURNE. Yes, sir.

Senator DECONCINI. I was told that it's 3 to 6 weeks to get a hernia operation; that a veteran would have to wait.

Mr. BOURNE. Three weeks would not be unusual. That's not because of lack of ICU beds or recovery beds.

Senator DECONCINI. It's not? What is it?

Mr. BOURNE. Well, it's the demand for service. We have five operatories. A hernia, in normal instance, is not—is an elective process and 3 weeks would not be an unusual amount of time to wait, nor would that be injurious in most instances to the patient's health.

If that would be an incarcerated hernia, or something of that nature, obviously then we would do—or provide that service earlier.

Senator DECONCINI. Do you think—do either of you think it is—besides being inconvenient—but not in the best interests of the safety of the veterans to have to travel from Prescott and other places in northern Arizona to come to your facility when they need inpatient surgery?

Mr. BOURNE. In some instances it could be, and that surgery should be done probably at the local level. If it's a life-threatening condition, obviously time and distance is a very important factor.

Review of the data, however, indicates that that's not often the case, and when it is the case then those patients then are cared for in the community, as we must do in Phoenix.

When we have a patient who has a life-threatening neurosurgical condition and cannot be transported to Tucson, we have that service provided here in Phoenix.

Senator DECONCINI. I have other questions for all of you.

Congressman Stump?

Mr. STUMP. Thank you, Mr. Chairman. Gentlemen, thank you for appearing before us today. Mr. Estrada, welcome to Arizona.

Mr. ESTRADA. Thank you.

Mr. STUMP. I hope we can offer more than you had down in Texas.

I know you have only been on board a couple of weeks, but I would appreciate it if you would thoroughly familiarize yourself with these figures that we're talking about as far as the surgical wing, because, believe me, we're going to look into it again.

Mr. ESTRADA. Yes, sir; I certainly will.

Mr. STUMP. I would ask you—and maybe you haven't been there long enough to be able to ascertain, but if we're having a problem retaining other medical personnel, other than surgeons or a related field like anesthesiology.

Mr. ESTRADA. I am not aware of any other problems at this point, sir.

Mr. STUMP. I know we lost a urologist, but there's nothing else to indicate that we're losing other key personnel up there for various reasons.

Mr. ESTRADA. No sir; I'm not aware of any at this point.

Mr. STUMP. Thank you.

Senator DECONCINI. Congressman Kyl?

Mr. KYL. Thank you, Senator. I would like to ask Mr. Bourne one or two questions.

First of all, are there any delays in surgery that are in the category of deleterious to the patient's condition, and if there are those kinds of delays, what can you tell us that you need to do insure that the problem is taken care of?

Mr. BOURNE. Well, in the instance where a patient's surgical condition is so acute that they need immediate surgery, we would then cancel the surgery scheduled for a patient whose condition is not immediate in nature and that is an optional kind of surgery.

In order to reduce the number of cancellations, we're going to—we must increase the surgical capability, again, over time, as I spoke of earlier. We must increase our ability to provide surgery.

We need more operatories. We're going to need, obviously, the staff to function in those operatories, and with the tremendous growth in Phoenix, in central Arizona—that's our PSA, central Arizona—we're going to continue to see 3 week waiting periods for a hernia and we're going to continue to see people cancel—their surgery canceled because there is an emergent case that has arisen.

And until we balance our ability, our surgical operatories, the number of operatories, the number of surgeons functioning, with the demand that's coming—that's here and is going to become more acute in the next 5 to 10 years, that problem would become more frequent.

Mr. KYL. And the problem might be exacerbated if people from Prescott have to come down and be a part of that system, too.

I hope that Mr. Miller is paying very close attention to some of these things, because it's very clear that Arizona is going to have to have a much higher—more significant allocation.

I note from your testimony, Mr. Bourne, that you say that we have received additional funds that partially reflect a growing patient activity, and we are hopeful that the RNA process will provide the funding.

Well, I suspect that Senator DeConcini and Congressman Stump and I and others will try to make sure that it's realized and it's not just a hope.

The final question I had is whether or not you are satisfied, and I would also ask this question on Mr. Boyd as well, with the provisions of the new law regarding incentives for nurses, and whether you have any message for us as to anything else that might be needed in addition to that which is in the new law.

Mr. BOYD. Well, Congressman, I think anything we can get to alevate the nursing shortage will be very much appreciated, particularly in the Veterans' Administration.

As I alluded to, and as is contained in my official statement, I would hope that our Central Office would consider, or give you, local management, more flexibility in the cafeteria of plans about pay or benefits that may be available to us in recuriting young nurses, particularly coming out of school.

A young nurse coming out of school is not particularly interested in what kind of a retirement program we have. They're looking at how many dollars they're going to take home in a pay period up front, so if we could have some flexibility in establishing our pay plans and rewarding those nurses that are very often, in many cases, mothers with small children at home required to work midnights, weekends, we need to have that flexibility to provide incentive to have those people come in.

Mr. KYL. Without taking any more time on that point, I hope that you will address those specific recommendations to Mr. Miller and he will in turn send them on up the ladder to the people in Washington, and if, as a result of the implementation of the law, all three of you believe that it didn't come out the way it's going to work the best for you, will you please let us know?

Mr. BOYD. Sure.

Mr. KYL. Good, Thank you.

Senator DECONCINI. Thank you. Thank you, gentleman, very much. We appreciate your testimony and being with us here today.

Mr. BOYD. Thank you, Senator.

Senator DECONCINI. Our next panel will consist of chief of staffs and chief of medicines. We will have Luis Garcia-Bunuel, Chief of Staff, VA Medical Center in Phoenix; Alfred Heilbrunn, Chief of Staff, VA Medical Center in Tucson; Johnny Lepperd, Chief of Staff, VA Medical Center in Prescott; and David Linden joining him as Chief of Medicine, VA Medical Center in Prescott.

Gentleman, one of your are going to have to sit over on this side, I guess. Very good.

Your full statement will appear in the record. I want to thank you gentlemen for the fine medical care that you are involved in delivering to our Arizona veterans. I've had experience in dealing with most of you on a number of occasions and we appreciate that effort. Let me first start with Mr. Bunuel.

If you would like to summarize your statement, Doctor.

STATEMENT OF DR. LUIS GARCIA-BUNUEL, CHIEF OF STAFF, PHOENIX VA MEDICAL CENTER

Dr. GARCIA-BUNUEL. Thank you for the opportunity to present my assessment on access of Arizona veterans to Veterans' Administration health care.

I will summarize some of the earlier statements submitted to you in writing that have to do with the growth of Arizona. Going directly to how it has affected the patient population at the Phoenix VA, I cover in my statement some figures which I will not read, but would read the percentages that they represent.

From 1986 to 1987 we saw an increase of 11 percent on the outpatient visits, and an increase of 7 percent of the number of patients hospitalized and treated.

From 1987 to 1988—and that, of course, is a projected figure, we anticipate an increase of 15 percent on the outpatients, and 11.5 percent on the inpatients treated.

Clearly, this is not a recent change—I haven't just selected these last 3 years. This has been a trend that you can see in previous years as well.

With the resource allocation methodology, RAM for short, there has been an introduction of productivity, and this has favored us—or rather than favoring us, it has recognized our efficiency in our workload, and we have been partly funded for the increased workload.

Eventually, when RAM has fully applied, this will again probably keep us in good activity—good shape to fill the new workload.

Concerning the Medical Center services to veterans from the Prescott area, although much of it is referrals from Prescott for surgical services, Phoenix also absorbs most of the oncology cases, which is here about 400 probably, as well as all medical problems of greater complexity.

Elective surgery cases from Prescott are placed on the same general schedule as Phoenix patients. Physician to physician contact between Prescott and Phoenix allows prompt intervention in the more urgent cases.

Counseling and psychiatric services for Vietnam veterans is available through our regular channels of the psychiatric and mental hygiene clinic and the inpatient services, psychiatric services.

In addition, we maintain a very close relationship—our psychiatric staff maintains a very close relationship with the Vet Center staff; so I think those needs are well covered.

The post traumatic stress disorder, PTSD, our unit has in place now for close to 4 years. It has seen over 172 veterans. This is a complex type of treatment and energy absorbing, because to be therapeutically successful it is considered that the patient groups must be small.

We have 16 beds, which—with two groups of eight patients each, and the treatment in our own particular area is 90 days; 3 months per group. In addition to that, many of them are followed up.

Concerning the nursing shortage, this has affected us just the same as the other hospitals. In our place we have an additional factor in the seasonal fluctuations, which make us become particularly short of nurses at the time when everyone in Phoenix needs nurses; that is, in the wintertime. Although special pay must help, this coming winter I expect to have some problems in that area.

This, coupled with the increasing number of aging veterans, is putting an additional workload on us, and we hope that we will join forces and will be able to face it. And this concludes my statement.

[The prepared statement of Dr. Garcia-Bunuel appears on p. 87.]

Senator DECONCINI. Thank you, Dr. Bunuel.

Dr. Heilbrunn.

STATEMENT OF DR. ALFRED HEILBRUNN, CHIEF OF STAFF, TUCSON VA MEDICAL CENTER

Dr. HEILBRUNN. Thank you. I appreciate the opportunity to appear today.

My views on the issues highlighted in the letter of invitation were incorporated into the written statement with Mr. Boyd, which was submitted prior to the hearing.

I would like to use the opportunity to make some comments about the Tucson VA Medical Center and some general comments about the issues.

The Tucson VA Medical Center is a highly sophisticated tertiary care facility with extensive additional programs in education and research. Clinically we provide referral services for the entire State veteran population in the fields of cardiac catheterization, angioplasty, cardiac surgery, neurosurgery and kidney transplant.

The Tucson VA Medical Center is the only Medicare-certified adult kidney transplant unit in southern Arizona, and we provide this service to nonveterans through sharing agreements.

We are closely affiliated with the University of Arizona College of Medicine, and provide clinical training for third- and fourth-year medical students, and a large number of interns and residents representing virtually all specialties except pediatrics and obstetrics.

Additional education affiliations exist in nursing, psychology, audiology, speech pathology, social work, pharmacy, and alcohol counselor training.

Our total research budget exceeds $1.3 million from VA sources, and we have a unique microcirculatory laboratory for a number of the key research efforts. These include investigations of some of the basic mechanisms of diabetes, a very common problem among veterans.

While the resources available to us have frequently not been at the levels desired, and at time required stringent economies, I can say without equivocation that not a single eligible veteran deemed to require hospital care has ever been denied admission to our facility.

Beyond this, our quality assurance and utilization review of VA activities would strongly indicate that the level of care being provided is excellent.

As we have for many years, we continue to provide surgical services for patients from the Prescott area whenever requested, and have always readily accepted urgent or emergent cases.

The recruitment and retention of nurses can be very difficult at times. If I may be permitted some personal opinion, and this has not been edited or reviewed at all, I think the problem is very broad and complex and cannot be defined simply as issues relating to pay, benefits or working conditions.

I believe it is linked to the changing perception of women's role in contemporary American society. Nursing as a profession has been traditionally viewed as a maternal, caring, serving activity, and these attributes don't seem to be as highly regarded anymore as the used to be.

Women today, if they're interested in the health field, tend to opt more for entering medical school, pharmacy or administrative positions.

Before the nurse staffing problem is resolved, not only must pay, fringe benefits and working conditions be improved, but I think the entire profession needs a new vision of its role. Thank you very much.

[The prepared statement of Dr. Heilbrunn appears on p. 80.]

Senator DECONCINI. Thank you, Dr. Heilbrunn.

Dr. Lepperd.

STATEMENT OF DR. F.C. LEPPERD, JR., CHIEF OF STAFF, PRESCOTT VA MEDICAL CENTER, ACCOMPANIED BY DR. DAVID LINDEN, CHIEF OF MEDICINE

Dr. LEPPERD. Good morning and thank you. I have submitted my statement to you all. I'll pick out a couple highlights, if I may.

Again, a personal opinion; I feel very strongly that the allocation of health-care resources to our Agency, which includes Arizona, has been affected severely by the national health-care system—national—which indeed, in my opinion, has become a great industry, and sometimes I think it's somewhat not unlike a Wall Street brokerage firm. That's my opinion.

The distances veterans have to travel in this State are tremendous, as you well know. This is coupled with a lack of transportation, with very little except in the cities.

This has complicated the entry of the veteran in northern Arizona into our system. Indeed, along the river—and I'll say Bullhead City to Topock—there are approximately 12,000 veterans right now that have to travel anywhere from 180 to 250 miles to reach Tucson, Phoenix, or Prescott, whichever way they go.

We at Prescott are now looking at a methodology in putting together figures that we can submit for possibility of having a clinic over there in order to reach those veterans.

Nursing; there is severe shortage in northern Arizona. I have had the good fortune of being a delegate to the State Medical Society for the past 5 years. As a result, I've learned to know many folks in the Arizona Hospital Association. I have canvassed the C.E.O.'s in northern Arizona and they're all having problems with nurses.

It's back to, "We take the kid out of the country and they go to the city, and they don't come back to the country." So what we're trying to do is work up a curriculum, we're doing it now with the Yavapai Community College, whereby we train nursing assistants—and I'll need help on this for tuition, et cetera—and try to keep those nursing assistants up there and give them a career ladder which is already in on board at Yavapai Community, and that's a 2-year nursing degree. Those are the steps we have taken there.

My personal observation indicates that our Phoenix Regional Office is no longer timely in responding to veterans' claims. I cannot speak to the resource needs.

Availability of counseling and psychiatric services from the vet center in Prescott I think is excellent. I do think the vet center lo-

cated in Prescott needs additional resources. I will allow them to address that.

Access of Arizona veterans to nursing home care, I think we're fortunate that we have, coming on board, a 60-bed nursing home care unit with the availability of adding to it with another 60 beds.

As we all know, this State does not have Medicaid. I know that AHCCS is in the process of being refiltered, so to speak. I hope it has done a good job.

I see many, many patients' spouses who—you know, Mom can't take care of Pop any longer, Pop has saved up $20,000 or $30,000; Pop has to go to a nursing home and all money is spent and what is left for Mom? I would hate to be in that position.

Surgery; I am a firm believer that when you are taking care of acutely ill patients you need an in-house surgical unit, period. I'll rest on that.

[The prepared statement of Dr. Lepperd appears on p. 91.]

Senator DECONCINI. Thank you. I don't know what else you could add on the surgery issue than what the Director said, Dr. Linden. Certainly we'd appreciate your testimony if you have any comments.

Dr. LINDEN. Well, I was told not to bring a prepared statement to answer any questions.

Senator DECONCINI. Very good. I do have some questions.

Dr. LINDEN. I would be happy to respond to any questions, particularly as they might relate to what it's like to be an internist, chief of medical service, at a hospital where there's no inpatient surgery.

Senator DECONCINI. We will get to that.

Dr. Heilbrunn, you mentioned something of real interest. I know Congressman Kyl has raised the issue here several times on the nurses. You point to the change of attitude and what have you.

What about the change of salaries for nurses? I don't have the figures here, but I've read some that they have just not kept pace with other professions, and what is the hope of retaining good nurses, if in fact, the monetary benefits are not there?

Dr. HEILBRUNN. Well, I think that's obviously one of the key problems, and based on my reading of some of the literature relating to the problem, I think it's not only the salaries but the progression over a career.

In other words, in many fields one can double, triple, quintuple their starting salary. In nursing, apparently, the opportunities between beginning salaries and maximum salaries are a very narrow thing.

Senator DECONCINI. Very narrow. What do you think—or Dr. Bunuel, do you have any suggestions—how do we raise salaries of nurses? It seems to me to be a chronic problem both in the nursing and in the education area.

How do we get the attention of those of us, and in your profession and the VA, that they no longer can get cheap nurses? They have got to pay a premium price and it means that it's going to cost more, but it's time that we do this. Do you have any suggestions?

Dr. GARCIA-BUNUEL. It has been repeatedly brought to attention that there are problems whenever there are budget restrictions. Nursing personnel are the major force in a hospital.

For instance, ours has a personnel of around 1,350, and of those over 400 are nurses, so a raise of salaries there is going to be felt in the budget.

Senator DECONCINI. What kind of salary increase do you—all three of you—think would be necessary to have nurses coming forward?

Do you have any suggestion? Have any of you given it any thought? Is it a 20-percent increase, 100-percent increase?

On the monetary side, do any of you have any assessments or comments or opinions on what you think the salary increase needs to be?

Doctor Garcia-Bunuel, do you?

Dr. GARCIA-BUNUEL. I would like to say two things. One, addressing the question, at this time I think 20 percent probably would be sufficient, but since there is a chronic shortage, that's going to mean more competition from other sources in the market.

The AMA has come up with a very controversial measure approach, a proposal, and that is the creation of a group of RC aides, registered care technicians, who receive relatively bare bones training to do the things that now many RN's are doing, the more direct physical needs for the patients, and those would be directly under physician control.

Now, that's one way around, to let the RN's with excellent training use their training in better-skilled areas and have that routine type of care in the hands of less-well-trained individuals, and therefore less expensive.

Senator DECONCINI. Dr. Heilbrunn, do you have any suggestions monetarywise?

Dr. HEILBRUNN. Not really.

Senator DECONCINI. You addressed the whole problem including that?

Dr. HEILBRUNN. I think the career area needs to include more opportunity.

Senator DECONCINI. And more money?

Dr. HEILBRUNN. Financial.

Senator DECONCINI. Financial opportunity as well.

Dr. Lepperd, do you?

Dr. LEPPERD. Yes, sir, I do. In my opinion, nursing personnel now are forced, in order to receive higher salaries, to go on to higher education, receive larger, bigger degrees—BSN's, et cetera—so that they are no longer in direct contract with the patient.

They go into education, they go into research and they go into administration. I'm not against any of the three, but this is the only ladder up. I think we have to make sure our salaries, to those working in the trenches and doing a good job, are commensurate.

I do have a very personal opinion that a well trained nurse should be started at a salary of $25,000 a year and should have the ability to go to $40,000 while working in the trenches. Personal opinion, Senator.

Senator DECONCINI. What do they have now? Do you know what that range is?

Dr. LEPPERD. I think we start at about $17,000, don't we?

Dr. GARCIA-BUNUEL. We go up to the low $30,000 range.

Senator DECONCINI. That's as much as a nurse can make if they stay in the ward or in the service?

Dr. LEPPERD. Yes.

Senator DECONCINI. That's a good point and I appreciate that.

Let me turn to the Prescott surgery problem. First I want to ask Dr. Linden a question as chief of acute medicine.

Do you believe that acutely ill patients are adversely affected by the lack of an inpatient surgery at Prescott Medical Center?

Dr. LINDEN. I believe frequently that is the case. I think that there are instances where patients are presented basically with a choice to take a 2-hour ambulance ride to Phoenix, or further to Tucson, or to be taken care of at the local hospital; and what distresses me is the second-guessing of review teams and so forth that second-guess the physician that made that decision to send them to a local hospital in the middle of the night with nobody around to support them except their own wherewithal, to then say, "Well, why did you send that patient to a local hospital rather than sending that patient to Phoenix?"

Senator DECONCINI. So that can be detrimental not only to the doctor, being second-quessed, but certainly to the patient.

Dr. LINDEN. Absolutely, and I personally think it would be nice if we were allowed to give the patient up front that choice. In other words, if they have Medicare——

Senator DECONCINI. You can't do that now, right?

Dr. LINDEN. Not as far as I can see it, but if they have Medicare or they have some other private insurance coverage, say, "Here are your choices. You can take this ride to Phoenix at some risk, or you can go to the local hospital."

Senator DECONCINI. Dr. Lepperd, can you help me—or maybe Dr. Linden—what has been the dollar amount of fee-basis referrals into the community of Prescott and to the Phoenix and Tucson Medical Centers in terms of travel and other related costs? Do you have those figures?

Dr. LEPPERD. I can give you some, Senator.

Our cost for surgical care—and this is in the private sector at Prescott without an in-house surgical unit, and these were consultations as well as procedures, ran approximately $350,000 to $450,000, to the best of my knowledge, this past year when we referred some 38 patients over there.

Now, you must remember, we have good rapport with the surgeons in the community and they will come out and consult, and not all those figures are added to the pure surgical, all right?

To the best of my knowledge it cost—while we were operating surgery the last year—$1.7 million to Prescott.

For the year following the closure of in-house surgery it amounted to approximately $2.3 million. This included operative procedures done in Phoenix and Tucson. I have no knowledge concerning cofigures.

Senator, it is extremely difficult to obtain these types of figures, and what I am trying to show is the cost of surgical care to the VA for veterans in our PSA.

Senator DECONCINI. Now, let me go over that again. Where did the $2.3 million figure come from?

Dr. LEPPERD. The $2.3 million is what we figured it cost to take care of all surgical patients the year we had no in-house surgery. Now, that included some 50 patients—38 to 50 patients—sent across the street to Yavapai Community Hospital.

Senator DECONCINI. OK.

Dr. LEPPERD. So you have to back that out, you see.

Senator DECONCINI. Yes. Now, what would it have cost, in your judgment, had you done that in-house?

Dr. LEPPERD. Well, the year before it cost—or 2 years before—it cost $1.7 million. Now, you've got to remember inflation, et cetera, et cetera, et cetera.

Senator DECONCINI. So even taking out 38 to 50 patients that you have to back out, you are still not, based on those figures, demonstrating any great savings.

Dr. LEPPERD. Well, not from my personal point of view, but then, Senator, I'm speaking for Prescott.

Senator DECONCINI. Well, that's what I want you to speak for, Dr. Lepperd.

Dr. LEPPERD. I will.

Senator DECONCINI. And boy, I hear from you and I'm glad I do, because I think somebody's got to speak for Prescott and you're a sound voice for it.

Is the curtailment of impatient surgery a factor in recruiting and retention of other medical personnel at your facility, either one of you or both of you?

Dr. LEPPERD. I'll speak to the recruiting of surgeons. Two years ago when this came up, we had no urologist for over a year.

I finally recruited one, but when the decision was made that, you know, surgery would probably go by the line, I had to tell that urologist, didn't I, that maybe he wouldn't have a job in a year.

I continued to recruit for two other surgeons who left for personal reasons.

Senator DECONCINI. So it has had a difficult—I mean it has had a real impact on being able to recruit.

Dr. LEPPERD. Suppose you were in California and I called you from Togas, ME, and said, "Come on up, the lobster's great. I've got a good job for you," and then I call back and say——

Senator DECONCINI. It may not be permanent.

Dr. LEPPERD. That's right. What would you say to me?

Senator DECONCINI. I would say I wouldn't want to go to Togas, ME, I don't care about lobsters or anything else; but if it was Prescott, I might.

Do you have anything to add to that, Doctor?

Dr. LINDEN. Well, just in the way of background, I spent 9 years in the U.S. Army, 13 years in private practice in El Paso and now, 3½ years with the VA, and I find it a very unique situation to work in an acute care hospital without surgery.

It's certainly not like anything I've ever done before, and I understand that the VA has other hospitals that work this way and there are others being contemplated.

I think that basically most of us have trained in hospitals in which there were complete general hospitals, and to have to work in this kind of situation presents some very unique problems.

I think that just in everyday operations of the hospital it's nice to be able to grab a surgeon to come take a look at a case because patients aren't neatly divided. They don't come in with an S or M saying "surgery" or "medicine" stamped on their chests, so you frequently have to consult; and to have that available, I think, is very important.

I think it has affected our ability to do some additional procedures. We have an excellent, will trained, all-board certified internist staff, have an excellent gastroenterologist who does a number of procedures, but there are several that we can no longer do or will not get into because we do not backup; such as doing percutaneous needle biopsies, liver, which is a fairly routine procedure except when you have problems, and when you have problems you need a surgeon right now.

So there are various impacts like that, that I think have affected the morale of our staff, and I think if we go more and more into extended care I would anticipate that at least—at least half of the staff will leave if we stop doing acute care.

Senator DECONCINI. Acute care? What happens now when a veteran comes in and you analyze, give them the review and what have you, and you determine that he has to have surgery, let's say it's an emergency. Does that patient have any input on what he wants to do, or she wants to do?

Can they say, "I don't want to go to Phoenix. I want to go across the street here"?

Can you use that judgment or that input in making your judgment?

Dr. LINDEN. Well, I think morally and ethically we have to take the patient's input. We are supposed to be the primary patient advocate, and it works both ways.

I can relate one case not too long ago where I came in to help the OD in the middle of the night with a patient who had gastrointestinal hemorrhage who just happeneed to be up visiting in Prescott and lives here in Mesa, and he wanted to come to the Phoenix VA because he had this acute hemorrhage.

My gastroenterologist scoped him and said, "You are bleeding. You need to have surgery right now and you need to go across town to the local hospital," and we were able to convince that patient and the family that this was necessary.

And indeed, he had to have emergency surgery. He would not have made it nor survived the trip to Phoenix.

Senator DECONCINI. But if in your case you feel that the service can be provided in Tucson or Phoenix and yet the patient says, "I don't want to go down there. I like it up here. I want to go here," what do you do, assuming that the service can also be provided by a community hospital? Do you then refer them?

Dr. LINDEN. Yes, sir.

Senator DECONCINI. One last question. In the case of emergency surgery, Dr. Lepperd, in most cases do you consider it—or Dr. Linden—do you consider it prudent medical practice to attempt to

transfer a critically ill patient to the Phoenix or Tucson Medical Center?

Dr. LINDEN. Well, sometimes we have absolutely no choice, anymore than Yavapai Regional Medical Center has a choice. You just have to do—we had a case a few months back in which a patient had a ruptured aneurysm and there was no care available in Prescott by either hospital, and the patient had to be transferred and had to stop off at Lincoln Hospital, couldn't even get as far as to Phoenix VA.

Senator DECONCINI. Thank you.

Congressman Stump.

Mr. STUMP. Yeah, I just had one quick question.

Dr. Linden, in the case of where you have emergency surgery like that that you are able to provide for in town, Prescott in this case, are there any problems up to then with the planning for the paying for that, and how do you do that? Where does that come out of?

Dr. LINDEN. Well, Dr. Lepperd can probably speak better to this. I personally don't understand, under the RAM—random allocation methodology—how this is supposed to be funded, because if we pay out of local funds, out of the hospital funds, we do not get work credit for that.

In other words, we do not generate the work units that relate to the amount of money that we're going to be making, so it's money out but not money back in.

Mr. STUMP. Doctor.

Dr. LEPPERD. Up until recently we were being reimbursed by our own Central Office for this type fee basis going to the private sector, both for clinics, acutely ill patients, consultations, et cetera.

That no longer exists. Any emergency now we take out of our own hide and our own hospital. So we have accomplished that successfully.

Mr. STUMP. What would that amount to in a year of time? Any idea?

Dr. LEPPERD. Well, yes, sir. It amounted to almost a million dollars.

Now, you have got to remember something else here, Congressman Stump. You see, in my opinion at least, the facilities at Tucson and Phoenix—their resources have been overrun by demand. I'm sure you are all aware of how Medvet was born in this State. It doesn't have anything to do with the VA, but it was born because veterans wanted service and we can't always give it.

It's like the hernia that you mentioned about a moment ago. It's not an emergency. I mean Mr. Bourne mentioned it, but if a veteran wants it done now, we just don't have the resources frequently to do it. It's difficult.

Mr. STUMP. Thank you.

Senator DECONCINI. Congressman Kyl?

Mr. KYL. I think, but for the time, all of us would really like to spend more time with the questioning, and I suspect that we will be able to do that in the future because—speaking for myself, but I'm sure the others concur—your views on this are extremely instructive to us and I really appreciate your testimony.

In view of the time, I'll not ask any questions, because Congressman Stump and I will have to be leaving in a few minutes.

I would just like to say, though, Senator DeConcini, that I've had an opportunity to review the testimony of Catherine Budd Hoffman and Denise Hallfors, who will be testifying soon, I presume, with respect to their suggestions on recruting and retaining nurses, and I find that there are numerous intriguing and retaining nurses, and I find that there are numerous intriguing suggestions from the people who probably know best what it would take to improve their situation, some of which deal with money, some of which deal with changes in the bureaucracy to respond on a more timely basis to the competition that other facilities present to the VA, and they're suggesting that if we could improve the timeliness of making changes, for example, we could more quickly respond to the market and thereby attract the right kind of nurses to the VA.

I find the suggestions to be very interesting and I wish that I could be here for their testimony. I worked with Denise Hallfors before and I know that the Nurses' Association is a very professional and very responsible organization, and I hope that we will be able to followup on their recommendations as well.

I very much appreciate the opportunity you have provided for us to be here today.

Senator DECONCINI. Glad to have you here. Just one quick last question that will probably be of interest to you gentlemen.

Dr. Lepperd, on the nursing home that's under construction there, is it on schedule? I know——

Dr. LEPPERD. Yes, we're ahead of schedule.

Senator DECONCINI. You're ahead of schedule? When is it going to open?

Dr. LEPPERD. Approximately May or June this coming year.

Senator DECONCINI. Since the administration has reduced the size of the facility to only half of what the original number of beds—down to 60—how long will it take for this new facility to reach its patient capacity, in your judgment?

Dr. LEPPERD. Senator, I think this has to do with my ability to recruit nursing people. I could fill it now.

Senator DECONCINI. You could fill it now, or within a very short period of time once it's open, if you had the nurses?

Dr. LEPPERD. Yes, but nursing personnel——

Senator DECONCINI. Based on that, what you are telling us is that there is going to be a need for additional beds there in a short period of time, assuming you get nurses.

Dr. LEPPERD. Yes, sir; and as you know, the footers are being laid so that it will be able to be added to.

Senator DECONCINI. Gentlemen, thank you very much.

I want to thank Congressman Stump and Kyl for joining me here. They will be leaving me to go back to Washington. We will take a 10-minute recess.

[A brief recess ensued.]

Senator DECONCINI. The committee will come to order.

Our next panel, instead of being the State Nurses' Association, we are going to turn to the panel consisting of Veteran Centers.

Like to have Ches Goodman, team leader, Vet Center in Phoenix; Dean McKee, team leader in Tucson; Richard Wamboldt, team

leader up in Prescott. If you all would come forward, just sit down, gentlemen, wherever you want to there.

I want to acknowledge also Representative Udall's representative here with us today, and I know they have a great interest in the area of their district over in Yuma having no veterans' facility at all, so we will certainly keep that in mind and maybe some of our veterans' organizations will speak to that.

Let's start with you, Mr. McKee. Do you want to summarize your statement? Your full statements will be printed in the record, gentlemen.

STATEMENT OF DEAN M. McKEE, TEAM LEADER, TUCSON VET CENTER

Mr. KcKee. Senator DeConcini and members of the committee, my name is Dean McKee.

As team leader of the Tucson Vet Center, I am please to have the opportunity to meet with you today and discuss the work with Vietnam veterans in Tucson, AZ.

I'm here to speak with you about the veterans we are working with, the progress we've made since the Vet Center opened in June 1981, our observations on the changing needs of our veterans, and our proposed efforts to meet those needs.

As you know, the Vet Center program has developed to address the continuing readjustment problems experienced by Vietnam veterans. These include posttraumatic stress disorder, problems with employment, substance abuse, marriage and family, and a variety of other issues.

In many cases these problems represent the psychological and social repercussions of military service during the Vietnam era.

At the time the Vet Center program was initated, many of these veterans had avoided or rejected services provided in traditional ways. At the Tucson Vet Center it has been our mission to address the readjustment counseling needs of veterans in southern Arizona, specifically veterans of the Vietnam era.

Our service area includes Graham, Greenlee, Pinal, Pima, Cochise, Santa Cruz, Yuma, and La Paz Counties. We are also responsible for Hidalgo County in New Mexico.

In this service area there are over 125,000 veterans. Of these more than 40,000 served during the Vietnam era. Southern Arizona is a culturally diverse area with a variety of people, including Anglo, Hispanic, black, and native American.

It includes both urban and sparsely populated rural areas. People from a variety of income groups are represented. The veteran population reflects the diversity of the general population with the result that there are many groups with unique and special needs.

We have made considerable efforts to meet the needs of this veteran popoulation. Services are provided at our Tucson Vet Center by a team leader, two counselors and an office manager. Also, counseling is provided by contractors in rural areas.

Since opening the Center in 1981 we have achieved a number of successes which we believe demonstrate both the availability and quality of services. During the time since 1981 we have provided

services for 3,497 new veteran clients and accommodated 16,416 client visits.

As a result of our efforts, many of these clients have completed a course of counseling and are demonstrating continued success, as well as success within their families, on the job, and in the community.

Though we have had problems and shortcomings, we are proud of our record of service to our veteran community. As I report our progress and reflect on the problems that still must be addressed in our client population, I am reminded of my testimony given during the Arizona Oversight Committee of 1982.

At that time I described our mission as reaching Vietnam veterans who had remained unserved by traditional means. We utilize short-term counseling techniques which relieve or reduce the readjustment problems they have presented.

I am now pleased to report we have achieved additional successes. Many of the Vietnam veterans with acute problems have been reached and helped. Many of those who have received counseling in the past are returning for help with problems that have become more chronic and complex. As well as suffering from readjustment problems, Vietnam veterans now have concurrent psychiatric, substance abuse and personality disorders which require long-term assistance.

As we become more aware of these changes in our treatment population, we continue to work closely with the Tucson VA Medical Center. They are providing valuable support with psychiatric treatment, consultation, and training.

With quality veteran care as our goal, we continue to successfully maintain our positive relationship with the Tucson VA Medical Center.

In addition, we are working closely with the Post-Traumatic Stress Disorder Inpatient Program at the Phoenix VA Medical Center. We have referred a number of veterans for treatment to this program.

The Phoenix staff has worked effectively with our clients and we are involved in aftercare planning to maintain continuous care for graduated clients.

In addition, we have referred some veterans to PTSD units in Menlo Park, CA, and North Chicago, IL.

In closing, I would like to thank you once again for the opportunity to give testimony before the Senate Committee on Veterans' Affairs. We are proud of our successes, humbled by our shortcomings, and eager to meet the challenges of the future.

In concert with our local VA facility, we are striving to meet the needs of our veterans and creatively adapt to future needs. Thank you.

[The prepared statement of Mr. McKee appears on p. 97.]

Senator DECONCINI. Thank you very much.

Mr. Goodman.

STATEMENT OF CHESLEY B. GOODMAN, JR., TEAM LEADER, PHOENIX VET CENTER

Mr. GOODMAN. Thank you, Senator, for the opportunity to appear before this committee. In that I've submitted written testimony, I'll keep my oral remarks very brief.

A lot has been said about population statistics and growth rate here in Maricopa County and Arizona as a whole. I simply cannot overemphasize these facts. I think this is one of the primary factors now that face Arizona veterans and veteran services at this point.

One thing that I have not heard mentioned to this point is the fact that Arizona, and Maricopa County in particular, are bottom in the entire Nation, in 52 States and territories, in mental health spending.

I think we cannot overemphasize the impact that this has on vets in our services and other mental health services provided by VA.

Senator DECONCINI. Good point.

Mr. GOODMAN. It's not our job to provide mental health services to the entire community, and yet, without these services being here, there are no resources to refer to. Numbers of people are referred to our services who might not be otherwise.

Since we have opened in 1980 here in Phoenix, by the very most conservative estimate, we have had an increase of some 20,000—21,000 Vietnam-era veterans from 1980 to 1988. This is a 37-percent increase.

We're still operating with the same size staff that we were operating—four FTEE that we were operating with in 1980.

Maricopa County alone has 60 percent of the State's Vietnam-era veterans. This year we have seen a total of 511 Vietnam-era veterans for a productivity far beyond requirement.

I have to point out we have seen 4,500 total veterans in the 8 years; a very, very productive amount, and yet this is approximately one-fourth of the Vietnam-era veterans that have moved into this community since 1980, not address the other 50,000 that were already here.

We're currently providing a consistently high quality service to Vietnam-era veterans. We continue to be involved in the treatment of Vietnam veterans in the inpatient program for PTSD at Carl Hayden Medical Center, provide presentations and professional consultations to other mental health agencies, maintain vigorous liaison with the Carl Hayden Medical Center and the VA Regional Office in Phoenix.

The center's services are currently supplemented by Arizona Department of Economic Security Disabled Veterans Outreach Program, the VA chronically mentally ill homeless program, work studies and volunteers.

We are immersed in the Vietnam veteran community. We're proud to continue to provide a high quality service in the face of this explosive population growth, very low community mental health spending, few community resources, a large homeless population, increasing accountability and increasingly complex cases as Mr. McKee pointed out.

Thank you.

[The prepared statement of Mr. Goodman appears on p. 97.]

Senator DECONCINI. Thank you, Mr. Goodman.

Mr. Wamboldt.

STATEMENT OF RICHARD WAMBOLDT, TEAM LEADER, PRESCOTT VET CENTER

Mr. WAMBOLDT. Yes, I'd like to thank Senator Cranston for asking me to be here today, and the chairman of this panel and the other panel members for giving me the opportunity to talk about the availability and quality of counseling services for Vietnam veterans from the vet center program.

In Prescott the vet center opened in 1985 as a four-person team. About a year ago we lost one of the counselors and now we're a three-person team.

I'm the team leader and I spend about one-third or about one-half of my time counseling, so we have about 1⅓ counselors to serve all of northern Arizona.

On the availability, further, we maintain regular hours from 8 a.m. to 4:30 p.m. We also hold groups 2 to 3 nights a week until about 9 o'clock at night.

We also provide a group over on the alcohol ward at the hospital. We have an 800 toll-free number within the State of Arizona, and our counselors are available through the hospital switchboard for crisis intervention evenings and weekends.

Since the vet center opened we've now seen, in the last 3 years, almost 900 veterans. We're averaging about 20, 23 new clients a month, and over 200 counseling visits per month.

We see about another 50 counseling visits through contract providers throughout northern Arizona. We have contract providers from California border to New Mexico border, all along I-40 there from Lake Havasu to Bullhead, Kingman, Riviera, Flagstaff, St. Johns, Springerville, Show Low, Sedona, Cottonwood, and White River.

It's really about the only way, with 1⅓ counselor, we can even make an attempt to serve northern Arizona; and really, everything north of I-40 is way out there. Even the contract providers don't get out that far.

Of course, the Navajo reservation, there's a lot of Vietnam veterns out there. I worked almost 6 years as a counselor at the Gallup, NM, Vet Center, and 87 percent of our clients were Navajo Vietnam veterans, and about half of them were from northern Arizona. So the Gallup Vet Center helps out there with seeing some of the northern Arizona veterans up in Four Corners area.

As far as—one way we try to reach—get counseling up on the Navajo reservation is through training for PHSIHS. I've conducted training for the—all the psychiatrists resevationwide a couple of times now during their annual mental health conference, PHSIHS, provided training on diagnosis, treatment of posttraumatic stress disorder and other readjustment problems and issues of Vietnam Veterans.

On the quality of counseling and psychiatric services for Vietnam veterans at the Vet Center, we feel it's very good within our limited resources. Both counselors—or the 1⅓ counselors are both

clinical social workers, members of the National Associations of Social Work, the Academy of Certified Social Workers, included in the Registry of Clinical Social Workers and diplomats in the clinical social work. In addition, both, before they came to the VA, worked in psychiatric settings.

We have four to five groups running all the time. We have a Tuesday night group for combat Vietnam veterans who have been through other vet center groups and still need something more.

We have a Wednesday night group for combat Vietnam veterans. We have a Thursday night group for graduates of the PTSD inpatient programs, and then we do the combat Vietnam veteran group in the alcohol treatment ward, where we get veterans coming from all over the State for that, and we do an intake group in the domiciliary.

And then we also see people individually; couples, families. We get clinical consultation from West Yavapai Guidance Clinic from the director and their psychiatrist.

We have quality assurance programs and certain teams that come in and review us, and, of course, the IGA, and the GAO was in to review us over in New Mexico. I think we have been holding up pretty good as far as the quality of our services.

We make probably 20 or more referrals a year to inpatient PTSD units. We have a real good relationship with Dr. Amato and Dr. Harrington and the staff in Phoenix.

There's about a 5-month waiting list, I believe, to get screened for that program, but we have a good relationship with the staff, and oftentimes we're able to get people in when there's cancellations and get them in a little earlier, and then we do followup and aftercare when they come back to our area.

We also have a good relationship with support facility. The chief of staff, as well as the personnel, supply, and engineering departments are also very supportive.

Within their limited resources in mental health we could probably get more support if there were more psychiatrists at that hospitals we could probably benefit from that. Oftentimes we're seeing clients in counseling that are not service-connected, and being service-connected is not a requirement at the vet center but we do counseling with people who are very depressed, suicidal, homicidal, involved in domestic violence, drug abuse, alcohol abuse and—and oftentimes we need to have them seen for medication evaluation as an adjunct to counseling.

But overall our support there is very good, and in conclusion I'd just like to say I think that the quality of the counseling is very good and we're as available as we can be with 1⅓ counselor.

[The prepared statement of Mr. Wamboldt appears on p. 104.]

Senator DECONCINI. Mr. Wamboldt, you mentioned 12,000 Navajo veterans. Are those—is that right?

Mr. WAMBOLDT. I believe that is the figure I was given by the coordinator of the VA's American Indian Outreach Program.

Senator DECONCINI. Are those figures for American Indians on reservations?

Mr. WAMBOLDT. On the Navajo reservation, yes.

Senator DECONCINI. And how many of those do you see, any of them?

Mr. WAMBOLDT. Well, from Prescott, just a few. When we were in Gallup, 87 percent of our clients were of the Navajo reservation.

Senator DECONCINI. What is your percent now of native Americans?

Mr. WAMBOLDT. Oh, it's probably less than 5 percent now. We have a contract provider, a clinical psychologist in Flagstaff, who is real good with Vietnam veterans.

She has had a postdoctoral training in treatment of PTSD and she's a trauma victim herself, a rape victim. She was married to a Vietnam veteran and she's in the process of doing some outreach from Flagstaff for us. She's been going up into Tuba City and is going to start seeing some clients for us there on the reservation.

Also, the Navajo tribe is in the process of helping her out with transportation and motel expenses to go to chinle and see some veterans for us there on the reservation.

Senator DECONCINI. Gentlemen, are you aware the question of closing some Vet Centers and moving others into the VA Medical Centers in their vicinity has arisen on more than one occasion?

I would like to ask each of you for your assessment of what effects closure and relocation efforts would have upon your Vet Center clientele. Should the Veterans' Administration attempt to close or relocate any of the three Arizona vet centers?

Do you want to start, Mr. McKee?

Mr. MCKEE. Well, sir, my personal opinion is that—I'd like to preface my remarks by saying I feel that the vet center is a confidential and secure environment that allows Vietnam vets to build a rapport with Vietnam veteran counselors.

For example, in my center there are two Vietnam infantry veterans and a Vietnam era veteran, and in that environment it's very easy to build a counseling rapport with our Vietnam veteran clientele.

And second, I think our veteran population has gotten very used to the nonmedical model and has—from 1979 to the present has become very secure and proud of our services.

With that in mind, I would say that there would be a great deal of client or veteran resistance to a move within the veterans medical center.

Senator DECONCINI. Anything to add, Mr. Goodman?

Mr. GOODMAN. I agree completely with Mr. Mckee. We have had occasion to survey the community, not so much from a veteran point of view, but from other service providers in the community.

Almost universally the response I received back from the community was, "Why is that?" It would probably be detrimental to our services in that there are still Vietnam veterans who feel much more comfortable in approaching the vet center for service than they might going onto hospital grounds.

Senator DECONCINI. Why? What's the resistance of going to North Seventh Street and into the—if the vet center was set aside there or someplace within the complex? What is the resistance?

Why would that be detrimental? I mean, what would your clientele tell you?

Mr. GOODMAN. I think part of the original purpose of the Vet Center Program was to try to provide a less formalized atmosphere and a less bureaucratic type of atmosphere.

Even assuming that we'd be located on an outpatient—or an outbuilding, away from the main hospital building, I think that that perception would still be held by a lot of people, by a lot of our veterans, as they approached the hospital grounds.

I think it's very important to note that one of the original missions that we established to ourselves was, as necessary, to refer people into the more traditional VA services.

I think we have been very successful at that and I think Vietnam veterans are much more accepting at this point of VA medical services than they had been at one point.

We continue to work very closely with the VA Vet Center, particularly with Psychiatry Services' Inpatient PTSD Program.

Senator DECONCINI. Do you have anything to add?

Mr. WAMBOLDT. Well, yes. I think, you know, if we were to move on the hospital grounds, I think that would be all right. We're just about 3 miles away from there and we have a good medical center up there.

We would lose some clients, though. We still get—we definitely still get clients coming in that will not go on the grounds of the VA Medical Center.

Senator DECONCINI. You would?

Mr. WAMBOLDT. We have clients living out in the mountains——

Senator DECONCINI. Why is that? They feel they have had bad service?

Mr. WAMBOLDT. They had a bad experience back 20 years ago and just refuse to ever go back.

Senator DECONCINI. I see.

Mr. WAMBOLDT. Mistrust, authority problems, you know. One of the symptoms of readjustment problems in PTSD, problems accepting authority.

Senator DECONCINI. In your gentlemen's opinion, are most of your clients—or do your records show—are most of your clients new patients or are they long-term patients that you have treated, and what is the ratio, or do you know?

I'd like to start with Mr. Wamboldt.

Mr. WAMBOLDT. I would like to address that first, if I may. We're seeing over 250 new clients a year, probably approaching closer to 300 now, and most of those people come back.

They get good service. They come back for counseling at least four, five, six times, and oftentimes for years, and there's one problem with that.

You are seeing all these new clients; pretty soon your caseload just swells and swells and swells with recurring visits, and if we're having any problem at all at vet centers I think it's just the tremendous caseload that results from seeing new clients that keep coming back.

Senator DECONCINI. More new clients, is that what you are saying?

Mr. WAMBOLDT. Yes, and recurring visits. Once they come in the first time they come back, and then your overall capacity——

Senator DECONCINI. Is that true in Phoenix?

Mr. GOODMAN. I think that we are experiencing a large demand from new clients as well as older clients returning for reasons that

we probably offer a much more sophisticated service and a much superior service at this point than we did 6 or 8 years ago.

Senator DECONCINI. What is the ratio?

Mr. GOODMAN. We have had 291 new clients to date since October 1 this fiscal year. During the same period of time we have had a total, including the new clients, of 550 veterans walk in.

So we have some carryover from last year as well as older clients that have returned for service at this time.

Senator DECONCINI. How about Tucson?

Mr. MCKEE. Well, basically, sir, we're about the same, 252 new clients, so far. We'll hit over 500 before the year is over with and we're at about 1,300 visits. We'll hit about 2,000 visits before the year is over.

But what I could add is that we do have a continuing need for both. We have new clients continuing to come and, like my colleagues have said, we have recurring clients, and we're in the business of managing symptoms and decreasing impairments with veterans and sometimes, depending on the uniqueness of posttraumatic stress disorder, it's seasonal, so it swells. It has hills and valleys so it's hard to predict.

Senator DECONCINI. Last question. The PTSD problems—are they improving or resolving in your judgment, or are they just simply lying dormant in a lot of Vietnam veterans?

Mr. MCKEE. Maybe I could respond to that, if I may first, sir.

Senator DECONCINI. Go ahead. You can go first.

Mr. MCKEE. I think resolvable is somewhat inaccurate. I prefer the word manageable.

Like I said, we attempt to reduce or control the symptoms, and once traumatized, it's an ongoing struggle which may last a lifetime.

Some veterans are in a dormant stage. Some veterans come in and we smooth the symptoms and get them back managing their lives, and it may be recurring down the road.

So it's never over with, but we continue to try to manage the symptoms.

Senator DECONCINI. Mr. Goodman.

Mr. GOODMAN. My own viewpoint is not terribly different.

The human being has marvelous mechanisms for—defense mechanisms for handling trauma and for being able to go on functioning in life. This is true of a large number of the Vietnam veterans that we see; veterans that have returned home, gotten their schooling, finished, gotten into the work force, gone on with their families until a here-and-now crisis or a very strong stressor hits that family—a loss of job, a death in the family, severe problems with teenage children.

At that point the stresses seem to overcome the defenses that have worked well all these years, and so at that point those more dormant symptoms may become a full-blown case of posttraumatic stress disorder.

Senator DECONCINI. Do you have anything to add to that?

Mr. WAMBOLDT. Well, I would agree with that. Oftentimes we'll see people come in that have been suppressing their symptoms with alcohol for maybe 15, 20 years, and after 15, 20 years of drinking have developed alcohol addictions, and then that creates prob-

lems with DWI's and loss of jobs and families, and then are forced to quit drinking.

And when they quit drinking, then the symptoms come out and the sleep disturbance, the nightmares; so 20 years later I'm—I thought that after over 6 years of being a counselor in the Vet Center and having counseled more than—probably more than 1,000 Vietnam veterans, I thought I was pretty well desensitized to some of the stories, but I'm still amazed. Sometimes these guys come in and haven't talked to anybody in 20 years.

Senator DECONCINI. Gentlemen, thank you very much.

It's very helpful, your testimony, and we'll do all we can to keep your centers operating. I think you are doing a fine job.

We now will have a panel of PTSD unit physicians, Jose Amato at the Phoenix Center and John Harrington, also at the Phoenix Center.

Dr. Amato, would you like to begin?

STATEMENT OF DR. JOSE F. AMATO, COORDINATOR, PTSD PROGRAM, PHOENIX VA MEDICAL CENTER, ACCOMPANIED BY DR. JOHN L. HARRINGTON, FORMER COORDINATOR

Dr. AMATO. Yes. My name is Dr. Amato and I am the present coordinator of the PTSD unit at Phoenix VA Hospital.

I'm very pleased to have the opportunity to testify in front of this committee in behalf of the veteran in general and the Vietnam veterans in particular.

Dr. Harrington and myself have been working in this program for several years, and Dr. Harrington has been the initiator of the program more than 3 years ago.

We are submitting a statement that Dr. Harrington will read, and after that we will be able to answer any question you have.

Dr. HARRINGTON. Senator, it's a pleasure to have the opportunity to provide information to the Senate Committee on Veterans' Affairs concerning the access of counseling and psychiatric services for the Vietnam veteran.

Prior to 1980, Vietnam veterans were primarily provided the same care as other eligible veterans at the Phoenix VA Medical Center. At that time, a staff group consisting of a psychiatrist, psychologist, social worker, and nurse attended a specialized training program for providing care to the Vietnam combat veteran.

This, group then formed the core for initiating a specialized treatment for Vietnam combat veterans. This was mostly done on an individual therapy basis, but some group treatment, both outpatient and inpatient, was established.

Likewise during this period, liaison was initiated with the newly opened Phoenix Vet Center. In October 1983, a multidisciplinary planning group, including Vet Center staff, was appointed by the Medical Center's Mental Health Council to identify specialized treatment and staff training needs required to provide optimal care for Vietnam veterans.

In November 1983, this group recommended the establishment of a specialized inpatient treatment unit with an expanded outpatient program for combat posttraumatic stress disorder, or PTSD.

This was endorsed by the Mental Health Council. A proposal was submitted to the VA Central Office in May 1984, consistent with the planning group's recommendation.

This included a needs assessment, which estimated that 5,000 to 7,000 Vietnam veterans in Maricopa County alone were in need of some type of psychiatric care or counseling.

The planning and implementation for a 16-bed inpatient specialized treatment unit was started in fiscal year 1985, with increasing input and participation from Vet Center staff.

In January 1985, the first patients were admitted to the PTSD Program. The program has assessed over 300 veterans, and of these 70 percent have been accepted for treatment and 127 have graduated.

During the past year, 85 percent of the veterans admitted have graduated from the program. The program's current average length of stay is 87 days. It is a very intensive treatment approach and addresses the psychological, physiological, social, interpersonal, et cetera, needs of the multifaceted needs of the combat veteran. Recently, several Korean combat veterans have also been admitted to the program.

The responsibility for followup care for graduates of the program has been shared with the staff of the Vet Center, both in Phoenix and in Tucson and in Prescott and the mental hygiene clinic.

The mental hygiene clinic has continuously provided screening for all veterans, outpatient treatment for eligible veterans, and referral to the inpatient psychiatric service as indicated.

Outpatient treatment is provided for service-connected veterans and a group of nonservice-connected Vietnam veterans, particularly those who are in active treatment at the Phoenix Vet Center.

Currently there are over 100—and our statement says 200—but 100 nonservice-connected Vietnam veterans being followed in the mental hygiene clinic, with 50 percent of these being combat veterans. Psychiatric consultative supervision is also provided to the Phoenix Vet Center staff.

The Phoenix PTSD Program is one of 13 such VA-designated programs in the country. It is recognized for its general and innovative approaches to treatment.

The program staff has been involved in organization and participation in local, regional and national seminars and programs for the diagnosis and treatment of combat posttraumatic stress disorder.

The program is a crucial part of the availability and continuity of care provided the Vietnam veterans in this State, and maintains a close working relationship with the vet centers in Phoenix, Tucson, and Prescott.

The Phoenix Vet Center staff has provided extremely valuable clinical assistance to the program. Currently, within budgetary restraints, it is our opinion that the specialized treatment needs of the Vietnam veteran in the Phoenix area are being appropriately addressed.

The increasing number of veterans who are coming to this area has placed a strain on available resources. The problem of availability of care for Vietnam veterans, as well as all veterans, is what we see as an ongoing challenge.

[The prepared statement of Dr. Amato and Dr. Harrington appears on p. 107.]

Senator DECONCINI. Thank you, doctors.

What would you recommend as to the size of the unit which would address this population that is growing?

Dr. HARRINGTON. Our initial proposal was that we would have a unit of 30 beds and would have an extremely active outpatient component.

However, the allocation of funds and the full-time equivalents was less than a third of what we had proposed, and so in essence it was back to the drawing board and we came up with the 16-bed unit that we have now.

Senator DECONCINI. Are you saying that you need to almost double that number?

Dr. HARRINGTON. That was our estimate back in 1983, yes.

Senator DECONCINI. Does that still stand?

Dr. HARRINGTON. I would say so.

Senator DECONCINI. What is the average waiting time for admission to one of the units?

Dr. HARRINGTON. We currently have a waiting time for assessments, and that waiting time is about 5 to 6 months at the present time.

Senator DECONCINI. That's a long time, and what do you do in between then with them? Anything?

Dr. HARRINGTON. Well, many of the referrals come from the Vet Centers themself, and they continue to provide——

Senator DECONCINI. They just continue to provide counseling.

Dr. HARRINGTON [continuing]. Counseling for them.

Senator DECONCINI. What changes, if any, have been made in the length of stay of the PTSD, alcohol/drug abuse and long-term psychiatric programs since you have been into it? Have you altered the original program?

Dr. HARRINGTON. Yes; there has been a change in the length of stay in the PTSD program. When we initiated the program, the average length of stay for the first year or two, for a person that graduated, was about 108 to 110 days.

As of about a year ago, associated with many factors, we have now changed the length of stays of—the maximum length of stay in the program is 90 days.

Senator DECONCINI. And what brought that about?

Dr. HARRINGTON. This was——

Senator DECONCINI. Primarily; financial restraints, or that the program was working successfully and you don't need them that long?

Dr. HARRINGTON. I think it's combination of both, probably, but the initial pressure was due to the fact that of—the DRG compensation for the treatment did not reflect the duration of treatment and the intensity of treatment that was required, and so there was an effort not only on our unit, but on all units in the country, to try to scale back; for those who were beyond a 90-day period, to try to come up with a length of stay that was consistent with reasonably good care and still did not cause a great deficit.

Senator DECONCINI. You both feel, Dr. Amato and Dr. Harrington, that 90 days, you know, does provide that equivalent care that 108 or 110 did?

Dr. AMATO. With the complexity of our program, this is the length of stay that we considered that it is appropriate.

Now, we know that there are other programs in the country with different approaches, and they could change the length of stay. However, our treatment approach required 90 days and we find that adequate.

Senator DECONCINI. From a medical point of view you feel that that is not only adequate, but enough time?

Dr. HARRINGTON. My opinion is that for what we are doing at the present time, 90 days is enough time.

I think one of our problems is, once they go through the program, in having the availability of aftercare staff to provide the support that is needed.

The vet centers have done an outstanding job in providing support for this, but the reality is that we do not have the—the capability of providing the type of outpatient followup that we would like to have.

Senator DECONCINI. The followup is what you need more of, and that is, in your opinion, beyond the capacity of the vet center?

Dr. HARRINGTON. I believe it is, as our graduates increase in number.

Senator DECONCINI. Because of the size of the vet centers or the personnel that they have?

Dr. HARRINGTON. No, because of the size of the staff at the vet center.

Senator DECONCINI. In other words, they're capable of doing it if they had more people.

Dr. HARRINGTON. Yes.

Senator DECONCINI. Thank you.

Gentleman, thank you, doctors, very much. That's very helpful to us.

Next panel will be service officers. Oh, excuse me. I take that back. We are going to go back and do the panel on the State nursing association. We'll have Denise Hallford and Catherine Budd Hoffman.

We appreciate the fine work that you have done with the Arizona Nursing Association, Miss Hoffman. We've worked with you over the years and you've demonstrated some outstanding service to us and advice and counsel, and we look forward to your testimony today.

If you will summarize it, I would appreciate it. We will accept full statements of both you and the executive director, or anybody else in your profession, because we are very much in need of some information please proceed.

STATEMENT OF CATHERINE BUDD HOFFMAN, MEMBER, ARIZONA NURSES' ASSOCIATION, ACCOMPANIED BY DENISE HALLFORS, EXECUTIVE DIRECTOR

Ms. HOFFMAN. Thank you. My name is Ann Hoffman. I'm a registered nurse, and in response to Medicare's prospective pricing

system, hospitals have cut nursing budgets, laid off nurses, and halted recruitment and retention efforts.

We believe that as a result of these developments, the average workload of registered nurses has increased markedly and has been largely responsible for the acute emergence of the current nursing shortage.

In order to alleviate the immediate shortage, AZNA, Arizona nurses, as a member of American Nurses' Association, endorses the following short-range strategies for dealing with the nursing shortages: Immediately increase the time that registered nurses spend with patients by reallocating resources and developing staffing to change the salary and benefit structure to retain experienced nurses; to help nurses who work part time to return to full-time employment; to employ nursing assistants and licensed practical nurses to assist registered nurses in the support tasks essential for patient care.

Regarding the ability to change salary and benefit packages, my VA nursing colleagues emphasized that a shorter turnaround time is imperative on these matters from the Washington offices. As long as 4 months' time can transpire between suggested changes at the local level and a response from higher authority.

This does not take place in VA hospitals in a competitive—I'm sorry, this does not place VA hospitals in a competitive posture for nurses. My own experience with such changes in the Phoenix Valley is that salary adjustments and perks can be negotiated and marketed as frequently as every other month, if needed, to compete.

I am from Tucson, AZ, and I do work closely with the VA hospital in Tucson. I am a nurse at the Pima County Adult Detention Center, more recently—or, as we know it more by—as a jail. So I am involved with them concerning also their mental health people because we do have a lot of clients that go back and forth.

And I would be happy to take any questions.

[The prepared statement of Ms. Hoffman and Ms. Hallfors appears on p. 110.]

Senator DECONCINI. Thank you, Ms. Hoffman. Maybe you can help us. Do you know any of the facts at the Phoenix Medical Center; the problems with the nurses there from the association's point of view?

Ms. HOFFMAN. They brought them only in the paper. I think that this could be followed up in any matter with Nurse Hallfors.

Senator DECONCINI. Only in the paper form. We'll accept that. We'd like to pursue that, of course.

Ms. HOFFMAN. Sure.

Senator DECONCINI. Let me ask you this. What would be your recommendations to the Congress of the United States to alleviate the—or overcome this severe problem? Is it simply a matter of salaries?

If we had a 20-percent salary increase, if we had information like Dr. Lepperd indicated, that if the salaries stated at $25,000 and went up to $40,000, would that do it alone, or does it encompass other benefit and job issues that are really a problem to working nurses and the lack of?

Ms. HOFFMAN. It seems to be twofold. Yes, if there were definite encouragement of salary, that would be—would compensate these nurses so that they can afford tennis shoes for their children, or universities for their children as they grow older.

We who are more experienced cannot afford to stay at the bedside because our salary ratios do not go up. We are forced into other areas. That's a true statement.

He also alluded as far as they need to take a good look at the—what nurses are doing. Unfortuantely, when we come into an area that is short on support staff—in other words, if we end up making beds instead of taking care of our nursing things that we should be doing, then we're wasting nurses.

Senator DECONCINI. Do you agree that if the salaries were substantially increased, that any good administrator would—some of those things would be corrected?

Ms. HOFFMAN. Yes. I do agree.

Senator DECONCINI. They would just say, "We just cannot afford having a $40,000 nurse here making a bed."

Ms. HOFFMAN. Yes.

Senator DECONCINI. They would just say, "And we have to get somebody else."

Ms. HOFFMAN. Yes.

Senator DECONCINI. So, the salaries really do have a tremendous impact here, don't they?

Ms. HOFFMAN. It would make a lot of difference.

Senator DECONCINI. What additional incentive programs would you recommend to attract nurses out of nursing schools, besides a salary? What's on their minds when you see these new nurses come out, or what's on their minds when they don't come out or they tell you they decided to do something else?

Ms. HOFFMAN. I think we also need to take a good look at putting some more emphasis upon the fact that nurses need to be at a level where they go in at a bachelor of science degree.

I think registered nurses should be on at least a level that we look at with our teachers. When we look at our teachers, I would be hard pressed to be happy with my children to be taught by someone who only had a 2-year program.

Senator DECONCINI. Sure.

Ms. HOFFMAN. You know. Grandma went to Tempe Normal, but I would not be real happy with somebody graduating from Tempe Normal.

Consequently, I feel that nurses should be professional, much more professional. I think that needs to be addressed.

Senator DECONCINI. Of course, now that it's ASU, you would be quite happy with that.

Ms. HOFFMAN. Yes.

Senator DECONCINI. The turnover rate for registered nurses in medical district 24 for fiscal year 1987 was 24.3 percent and the vacancy rate was 4.6 percent.

Do you know how this compares with the private sector? Do you know what the turnover rate is?

Ms. HOFFMAN. I don't know the turnover rate. That would have to come from—probably from Denise Hallfors.

Senator DECONCINI. Fine. Thank you very much for your testimony. We will put your full statement in record.

Ms. HOFFMAN. Thank you.

Senator DECONCINI. We'll now turn to the service officers, representatives. We'll have Art Brest, Deputy Service Officer, The American Legion.

Excuse me. We are having a little logistical change here. Let's have the service officers as well as the commanders come up, so you can all move down here.

Bob, you're going to have to move and bring some other chairs in.

Mr. CLARDY. Excuse me, sir. For clarification, that's department service officer.

Senator DECONCINI. Department service officers, thank you. That will be Tom Clardy, department service officer for VFW; William Lyght, national service officer, Military Order of Purple Heart; Nelson McDevitt, national service officer for AMVETS; and Paul Smith, National Service Officer, Paralyzed Veterans of America; and is Representative Hartdegen here?

We will have Richard Hoover, past national president, Paralyzed Veterans of America; Earl Bowers, Past department commander, Disabled American Veterans; Don Maynard, department commander of Veterans of Foreign Wars; and Lencho Othon, department commander, The American Legion—glad to see you here, Lencho. I've known your father for many, many years—and Raymond Pelkey.

Now, are we going to be able to get everybody here?

We'll start off with Richard Hoover, the past national president of the Paralyzed Veterans.

STATEMENT OF RICHARD D. HOOVER, PAST NATIONAL PRESIDENT, PARALYZED VETERANS OF AMERICA, ACCOMPANIED BY PAUL SMITH, NATIONAL SERVICE OFFICER

Mr. HOOVER. Thank you, Senator. Mr. Chairman and members of the committee, it is an honor for me to present the views of the Paralyzed Veterans of America on the important issue of access of Arizona veterans to Veterans' Administration health care.

Mr. Chairman, as a constituent and resident of Arizona, as well as a consumer of VA health care, I hope to be able to provide this committee with some insight into the problems being faced by Arizona veterans with regard to VA health-care delivery.

PVA, in 1987, published the results of its health-care study entitled, "Veterans Health-Care Actions and Interactions." PVA contracted with the American Health Planning Association to study the impact of both proposed and enacted policy changes at the national level which affect veterans' health-care delivery.

The study focused on four medical districts in the VA system to provide a cross section for analysis, medical district 24 was included in this study in detail, medical district 24 contains one of the largest geographic areas incorporated into a single VA district. It includes the States of New Mexico, Arizona, as well as 88 counties in Texas.

The Sun Belt region in this area is experiencing rapid migration from other regions, with a population growth projected to exceed 30 percent in the next decade. Arizona is the fastest growing of the States in medical district 24.

The veteran population in Arizona was 371,000 in 1980. This number is expected to reach 393,000 by 1990. The VA operates three medical centers in Arizona with the total number of beds 1,507, of which 1,132 are acute and intermediate, 161 are nursing home, and 214 are domiciliary.

Aging of the veteran population in medical district 24 will increase the need for chronic care beds to a projected census of 1,486 in 1995, a substantial increase over 1983's 686 beds.

The veterans for whom the VA accepts responsibility may be cared for in VA-owned beds, community beds under contract, or in State home beds. The district plans to meet 15 percent of the total need for nursing home beds among veterans by 1995.

Taking into account the substantial increase in the elderly population projected in the 1990s, the existing VA policy, which calls for 40 percent utilization of community beds, could result in displacing non-VA patients from the scarce supply of beds in the absence of construction of sufficient beds.

In conclusion, given the projected increase in need for community nursing home beds, to meet the needs of community residents, the district's proposed strategy concerning the number of veterans to be supported in community beds by 1995 is unrealistic unless there is considerable construction which takes place. Otherwise, the VA will be competing for available beds with other Federal payment programs such as Medicare and Medicaid.

Mr. Chairman, in 1983 the Administrator of Veterans' Affairs directed the plans for a Veterans' Administration prototype nursing home to be established. After this had been accomplished, other Government agencies and veterans' service organizations expressed concern that the design did not comply with minimum Federal accessibility standards.

In 1985 the VA Inspector General, upon examination of the design, agreed with that position. The VA is rapidly turning an unacceptable prototype into the standard of the agency. It would be disastrous and quite expensive to have to retrofit completed facilities.

I urge you, Mr. Chairman, to urge the Veterans' Administration to act quickly on correcting what is clearly an unacceptable design.

As the demand for VA health care rises, so too will the need to recruit and retain qualified nurses to administer that care. The critical shortage of registered professional nurses which exists today is a national problem.

The Committees on Veterans' Affairs in both House and Senate have demonstrated a strong commitment toward resolution of the nursing shortage being experienced by the Veterans' Administration.

The statistics say that the proportion of vacant positions for registered nurses in hospitals has doubled between December 1985 and December 1986, reaching the levels of the last national shortage in 1979.

The VA's report in 1986, Survey of Health Occupational Staff, identified seriously difficult staffing problems with regard to registered nurses at both VAMCs in Phoenix and Prescott. The VAMC Tucson staffing conditions for registered nurses were described as moderately difficult.

At the February 3, 1987, hearing of the House Committee on Veterans' Affairs, the Administrator was asked a question regarding the shortage of VA registered nurses, to which he replied: "Based on across-the-board data as recent as the last 60 to 90 days, we found that there is, overall, no nursing shortage."

It is this lack of commitment or cognizance on the part of an insensitive administration, compounded by public misinformation, general malaise and bottom-line budget managers who tend to make decisions in a vaccum, who cause the professionals' cloak of dedication to begin to fray. The impact of this issue needs to be magnified, not minimized, if a reasonable solution is to be realized.

The nurses leaving the Veterans' Administration have experienced working short staffed with little or no support, excessive overtime, and endured many weekend and off-shift tours of duty. Some of the difficulties of these professions can be resolved with higher salaries, some with greater educational opportunities, and some with more career mobility.

Each has its own unique needs, but one requirement all have in common is the need to know that the administration is committed to them and the maintenance of quality VA health care.

Authorizing salaries which are lower than hospital maintenance workers' is not commitment. Asking an employee to work so short staffed that he or she is actually putting his or her professional license in jeopardy is not commitment.

And when an institution fails to reimburse or otherwise discourages its employees from continuing their professional education, it is the same as saying, "We do not have a vested interest in your future, we are indifferent toward your professional improvement, and we are satisfied with the status quo."

The PVA believes that when a health-care professional stops pursuing new knowledge, his or her professional growth stagnates.

When any of these conditions exist, the quality of care received by the veteran is reduced; and perhaps no one knows more acutely than our members who have suffered a catastrophic injury. Quality of care can mean the difference between life and death.

Thank you, Mr. Chairman. I'll be delighted, when the time comes, to respond to any questions that I can.

[The prepared statement of Mr. Hoover appears on p. 119.]

Senator DECONCINI. Thank you, Mr. Hoover. I appreciate your testimony. It was very helpful and gives us a good synopsis of just exactly where we are.

Mr. Bowers.

STATEMENT OF EARL W. BOWERS, PAST STATE COMMANDER, DISABLED AMERICAN VETERANS

Mr. BOWERS. Thank you, Mr. Chairman.

First, I must state that our department commander, Carl Bursom, is incapacitated and in the hospital at this time. He could not make it.

Our national service officer, Larry Dawson, had another commitment for this time today so, obviously, I'm going to be the one to appear on behalf of the DAV.

Mr. Chairman, I wish to express my appreciation to Senator Cranston and to all of the members of the Senate Committee on Veterans' Affairs for allowing me this opportunity to appear here today.

On behalf of all Arizona disabled veterans, I thank you.

The health-care concerns of disabled veterans in Arizona are very real. They should and must be addressed. Due to the influx of veterans moving into Arizona for health reasons, and the winter visitors who spend 6 to 9 months out out of each year in Arizona, the Veterans Administration health-care systems in Phoenix, Tucson, and Prescott have become overburdened, inadequate and obsolete.

As you may recall, I appeared before this committee in February 1982 on behalf of the Disabled American Veterans. Obviously, the testimony given by me, and others for that matter, had very little or no impact whatsoever. Nothing has changed.

In fact, the veterans' health care is progressively vanishing from the reaches of veterans. Veterans' health care diminishes with each new appropriation.

Mr. Chairman, I'm not going to bore this committee with so-called statistics, for statistics are nothing more than eyewash. They can be bent, twisted and slanted in any direction to satisfy one's point of view.

The facts and the realities in this urgent plea is for the proper and adequate funding to maintain an effective and competent health-care delivery system for America's freedom fighters, the disabled veterans.

Veterans should not have to plead and beg for benefits they earned on the battlefield. When 100 percent service-connected disabled veterans must seek outside medical services in the private sector at their own expense, it is time to sound the alarm and let the President and the Congress know that the U.S. Government is reneging on their commitment to disabled veterans.

Millions of young Americans upheld their commitment to the U.S. Government. That commitment was to defend the freedom of the United States at all costs.

A great many young Americans answered the call to duty and paid a very high price for that freedom. They gave their lives, some never having had the opportunity to vote in an election.

Those who were fortunate enough to survive returned with their minds and their bodies abused and maimed, while others were disfigured and dismembered.

I am inclined to believe the present administration has no compassion nor sensitivity toward those of whom they speak so eloquently when the occasion serves their purpose.

Flowery speeches on the beaches of Normandy or kind words at the Tomb of the Unknown Soldier will not heal the war-ravaged minds and bodies of veterans, nor will accolades of praise on Me-

morial Day and Veterans Day for those who defended freedom with their lives.

Mr. President and Members of Congress, disabled veterans need adequate and appropriate appropriations to fund the health-care needs of veterans. Kind words and applause will not suffice.

All we're asking the Government to do is uphold their end of the commitment by providing sufficient funding to serve the needs of veterans with war-torn bodies and diseases acquired while serving the United States in foreign countries.

Is that too much to ask for of a grateful nation in exchange for services rendered?

As a past State commander of the Disabled American Veterans, a member of the Military Order of the Purple Heart, a member of the 87th Infantry Division Association, a member of the Air Force Sergeants' Association, and a member of the American Association of Retired Persons, I have had the opportunity to travel throughout Arizona.

I have talked to veterans, families of veterans, widows of veterans, and from time to time I have talked to sons and daughters of veterans. The No. 1 topic of discussion is health care for veterans. The question most asked is, "Why is the Federal Government reneging on health care to veterans?"

The complaints I'm hearing come in all categories, ranging from 6 to 8 hours' waiting time to see doctors, denial of medical services at medical centers, veterans traveling long distances to medical centers and then being told to come back the following day because the doctor is overbooked, waiting for months to obtain an appointment, denial of certain medications simply because they can be purchased over the counter in a drugstore, too little time spent by rating doctors in evaluating veterans' health problems, veterans overmedicating themselves due to the inadequate supervision by doctors writing prescriptions, drug profiles not being screened when new prescriptions are being written, adjudication of ratings based on a 10-minute or less rating exam by VA doctor, possible violations of the Federal Privacy Act concerning veterans with psychological disorders, and the chief complaint in regard to the VA regional office is the lack of response or acknowledgement to letters of inquiry from veterans or their families.

I am familiar with one case where the veteran's wife drove him to Tucson to the Tucson VA, which is 280 miles round trip, for an eye appointment.

When the veteran arrived he was told the procedure could not be accomplished due to the retirement of the technician who operated the equipment. It was stated that the procedure must be accomplished on a fee basis and permission must be requested.

In the interim, the veteran went to a private sector eye clinic and had surgery performed and purchased new glasses at his own expense.

I know this incident because it cost me $500. Mr. Chairman, I could cite volumes of complaints that veterans or their families have shared with me. However, these veterans refuse to put these complaints in writing and sign them, due to the fear of reprisal.

Over the past several years I have advised veterans and families to submit their complaints to the Office of Senator DeConcini if the

veterans's service organizations cannot assist them. I am certain the Office of Senator DeConcini has received numerous letters concerning veterans' health care.

I will not take up any more time, for I know there are others who wish to contribute to these hearings. I have attached letters of complaints I personally have encountered in the veterans' health care. I am confident others will also submit letters of complaint.

[The letters are being retained in the committee files.]

Mr. BOWERS. Mr. Chairman, at this time I'm going to have to delete this next sentence I have in here. It's already been mailed to Washington. I was not intending to represent the Disabled American Veterans this morning, due to the fact that I thought the commander or the service officer would be here.

In view of the fact they are not here, I would like to have the sentence deleted where I'm going to state: "Mr. Chairman, I wish to advise you and this committee that this testimony is not being given on behalf of the Disabled American Veterans organization. It is being given as an advocate for disabled veterans residing in Arizona who are fearful of losing benefits should they complain about inadequate Veterans' Administration health care." That sentence I wish to have deleted.

Senator DECONCINI. Without objection, the record will indicate that.

Mr. BOWERS. OK, I will continue with it.

It behooves all veterans to speak out freely for the benefits they have earned on the battlefield while preserving the freedom of the United States.

In conclusion, Mr. Chairman, I wish to thank you and members of the Veterans' Affairs Committee for allowing me to appear here today to speak openly and freely on behalf of disabled veterans. Thank you.

[The prepared statement of Mr. Bowers appears on p. 130.]

Senator DECONCINI. Mr. Bowers, I thank you, and also Mr. Hoover and the other gentleman here. I don't—I haven't seen all your statements, but I thank you for the leadership and willingness to speak out and bring the complaints to the members of the Veterans' Affairs Committee and to the Members of Congress.

That's where we have—if we have any impact, we know we need to know what's going wrong as well as what's going right, and we do know that some things go right at the hospitals and the care centers and the vet centers, but we also need to know the complaints that you brought out, Mr. Bowers, and have over the years to this Senator, that have been extremely helpful in trying to turn those things around.

I think also your national organizations that are represented here deserve a tremendous amount of credit. I recall so well at the beginning of this administration when there was such political euphoria and support for the President and his election, and your organizational members supported them tremendously, and when the first budget came out there was a $900 million reduction just in health care alone.

Some of you were involved in getting the national organizations to stand up early on and indicate that you as organizations and we in Congress were not going to accept those kind of reductions, not-

withstanding the popularity of the person who was in the White House. Maybe it's time that we do that again, and I look forward to working with you on it.

Now we'll hear from Mr. Pelkey.

STATEMENT OF RAYMOND A. PELKEY, AMERICAN EX-PRISONERS OF WAR

Mr. PELKEY. Thank you, Senator, and I thank the committee for the opportunity to be here today.

My testimony dealt solely with surgery in Prescott, therefore it has been fairly well covered. However, there is one item I don't think that has been dwelled on enough, and that's the importance of the veteran's family during his recovery period.

Now, if a veteran from the area served by the Prescott hospital in northern Arizona has to be transported to Tucson for surgery, he is not going to have the family unit with him during recovery, and this leads to lying there wondering whether things are right or wrong at home, and it's not the very best of situation. Thank you.

[The prepared statement of Mr. Pelkey appears on p. 137.]

Senator DECONCINI. Thank you.

Mr. Othon, I welcome having you here. We've known you for many, many years and your son's a good friend of ours.

STATEMENT OF LENCHO OTHON, DEPARTMENT COMMANDER, THE AMERICAN LEGION, ACCOMPANIED BY ART BREST, DEPUTY SERVICE OFFICER

Mr. OTHON. Thank you.

Mr. Chairman, members of the committee, the American Legion appreciates the opportunity to share with you its views on accessibility of Arizona veterans to Veterans' Administration health care.

The general area to be studied is the Department of Medicine and Surgery. Comment will be on specific categories as herewith mentioned.

First, overall issues of allocation of health-care resources to VA facilities in Arizona. At the outset, Mr. Chairman, we feel it necessary to reiterate the American Legion's longstanding philosophy on the funding of veterans' benefits and programs.

This organization has a total commitment to the health and well-being of the State's veterans, and therefore stands for full funding for veterans' programs. By that we mean there should be provision of such funds as are necessary to effectively carry out the programs that have been established by Congress.

We support all of those needed programs. Each of them had a purpose when enacted and each has been proven as currently meeting a legitimate need of the veterans' population. We are aware of no programs at the present that are superfluous or redundant.

However, we must again put forth our objection to the continuation of the means test and third-party reimbursement, Public Law 99-272.

Through survey visits of the VA Medical Centers by our Washington, DC, office, it has consistently been found that the means test appears to be more costly to administer than profitable to maintain.

The rate of means test collections to billings is far less than the initial VA projections. Furthermore, VA's own means test data has conclusively shown category C veterans average less than 3 percent of the systemwide workload.

The cost factor to maintain this program far exceeds the revenue realized by the U.S. Treasury. The means test and third-party reimbursement programs have changed the nature of the health-care progam by making it a cost program rather than a benefit program as intended by the American public.

Resolutions emanating from the 1987 American Legion Convention support continued opposition to means test and third-party reimbursement.

It is contended that by eliminating the means test and third-party reimbursement, more funding could be applied to those needed valuable health programs lacking proper funding.

Second, the availability of surgical service for veterans residing in the Prescott area; it is positively conceded that appropriate surgery service is of utmost concern to the American Legion, to our veteran population in northern Arizona.

However, of primary import is the formulation of a concrete mission statement for VA Medical Center, Prescott. If there is not a firm foundation for surgery and a well-grounded financial commitment for proper staffing, then success will not be had. Just to have a surgical unit for convenience's sake, without proper resources, may lead to an increase in claims under section 351 of title 38, United States Code, and the Federal Tort Claims Act.

This would be unfortunate and defeat the purpose for which the VA Medical Center in Prescott was established.

It is hoped that with the enactment of Public Law 100-322, problems unique to the residential areas of northern Arizona's veteran population will be rectified regarding surgery needs.

There is 2-year pilot program using mobile health clinics for eligible veterans residing at least 100 miles from the nearest medical facility. In conjunction with this new aid, from our understanding there are fee basis referrals to private medical facilities in addition to transfer to other medical centers—other VA medical centers.

Third, the availability and quality of counseling and psychiatric services for Vietnam veterans through the Vet Centers in Arizona, the inpatient PTSD unit at the Phoenix VA Medical Center and otherwise.

The American Legion supports continuation of the Vet Center Program, contingent on a plan wherein decisions on assimilating the Readjustment Counseling Program into the VA medical centers will be made on a case by case basis as the utilization of services diminishes.

The nationwide and statewide workload total for the vet center, the program in fiscal year 1987, show the highest level for new veterans clients and total cumulative visits since the inception of the program. Therefore, we adamantly oppose the idea of reducing the funding or the employment level.

Fourth, issues relating to the recruitment and retention of nurses at VA facilities in Arizona and the adequacy of current nurses' staffing levels at those facilities; we are pleased to note through Public Law 100-322 that more attention is being given to

the retention of nurses within VA medical centers; specifically, authorizing incentive bonuses, tuition reimbursement, and premium pay for registered nurses who work on Saturdays; in addition, requiring the Chief of the Nursing Service at each VA medical center to be included in each policymaking committee at that facility. This, we feel, is a positive step in recruiting and retaining this needed personnel.

Fifth, the access of Arizona veterans to expenses. A problem we have run into is that when a worthy and needy veteran is found to be a candidate for a nursing home contract through a VA medical center, funding is lacking.

This could either be on the initial contract or when the family has not yet found a suitable plan of action for placement. Of course, this is moot if the condition is service-connected in nature and placement is provided for.

We realize that there are forthcoming plans to alleviate this concern by way of the Indian School Act. However, we do not exactly know how long this will take. In the meantime, there is a gnawing need from our aging veteran population to resolve this issue.

A case in point is found within the letter attached to my prepared statement addressing the Payson, AZ, region, under the jurisdiction of Carl T. Hayden VA Medical Center, Phoenix, AZ. This unfortunate situation has also been noted on occasion in the VA Medical Center, Prescott, AZ, area.

We believe by inquiring to the social work service there it would be revealing as to the need associated with our aging veterans.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity.

[The prepared statement of Mr. Othon appears on p. 139.]

Senator DECONCINI. Thank you, Commander Othon, very much.

Mr. Maynard, very pleased to have you here today with us.

STATEMENT OF DONALD E. MAYNARD, DEPARTMENT COMMANDER, VETERANS OF FOREIGN WARS OF THE UNITED STATES, ACCOMPANIED BY TOM CLARDY, DEPARTMENT SERVICE OFFICER

Mr. MAYNARD. Thank you, Mr. Chairman. On behalf of the over 30,000 members of Veterans of Foreign Wars of Arizona and its Ladies' Auxiliary, I wish to thank the members of the committee for including us in this forum today.

I'm going to skim over this fast. Most of it has been covered, but there are some areas of concern which I want to put my finger on and express.

First to be addressed today is the allocation of health-care resources to VA facilities in Arizona. VFW's own record of supporting increased resources for health-care allocations to VA facilities in Arizona, as this is one of the fastest growing retirement areas in the United States and each year we get more and more snowbirds, or winter visitors during the winter months, which taxes our VA health-care facilities. We would suggest that the VA CO program funds for this purpose in the future; more funds.

The second issue is the availability of surgical services to the veterans residing in the Prescott area. My statement reads that we

cannot support the reopening of the surgical ward at Prescott VAMC.

I want to change that after hearing some of this testimony, but we cannot support this reopening of this facility until it's proven to us with facts and figures and dollars and cents that it is entirely necessary. There's too many discrepancies in the testimonies of the VA and other organizations, and this needs to be clarified before we could support that.

The third issue is the availability of quality—and quality of counseling and psychiatric services for Vietnam veterans through the vet center in Arizona.

To make that short, we believe they're doing a whale of a job, but, as usual, there's too little money too late. They're doing a good job but there aren't enough of them, and there aren't enough outreach so that perhaps the majority of the people who really need this care are not getting it. Many may not even know it's available because there is so little outreach.

The fourth issue is relating to recruitment and retention of nurses at VA facilities in Arizona, and very shortly we, in this department, will support any programs that will enhance the recruitment and retention of nursing, quality nursing staffs in our VA facilities.

VFW has worked many hours on nursing homes claims cases in Arizona and has found that the access of veterans to either VA facilities or community nursing homes has been outstanding by the medical center's concern.

To shorten that down, I'm just going to say the same thing. It's usually too little, too late. There are not enough beds, there are not enough funds to take care of the people who need this help.

And then to close this out, it's my opinion that in all of these programs there's a shortage of funding, therefore a shortage of personnel and facilities, and therefore our veterans, who have served their Nation well, are coming up short when it comes to the health benefits and care.

[The prepared statement of Mr. Maynard appears on p. 143.]

Senator DECONCINI. Thank you.

Mr. MAYNARD. Thank you, Mr. Chairman. I wonder if Mr. Tom Clardy, my service officer—if you could hear a few words from him.

Senator DECONCINI. Sure.

Mr. Clardy, I'm going to ask if the service officers have anything to add to these statements. Go ahead, Mr. Clardy.

Mr. CLARDY. Mr. Chairman, I have nothing to add to the statement the commander has made, other than on that Prescott issue. The reason that we are not supporting the reopening of that surgical ward at this time is due to the fact of—like the commander stated, there is too much conflicting information that has been put out here today, and we're doing a survey of that hospital facilities from 29—July 25 to 29, and we would like to reserve comment at this time based on that until after the survey of that hospital from the 25th to the 29th.

And I'm also meeting with my membership in northern Arizona on the 10th of July, and I'd like to propose this issue with those and bring that information back and include it with that survey that takes place on the 25th.

Senator DECONCINI. Very good, Mr. Clardy. When do you think we might have that information?

Mr. CLARDY. Bob O'Toole is coming in from Washington on the 25th and he'll survey it through the 28th. He'll give the outbriefing on the 29th, so——

Senator DECONCINI. Sometime in about the middle of August?

Mr. CLARDY. I probably won't be able to get it to you until probably about the middle of August.

Senator DECONCINI. That would be very helpful. I appreciate the VFW looking at it from the basis—I've talked to a lot of your members up there, just being up there over the 4th of July. There seemed to be a real strong support of it, but I think it's very important if we can substantiate that support with some good evidence, and I welcome that.

We will accept that information. Even though this hearing will be closed, we will accept it and provide that they will be added as an appendix to the hearing. Very good.

[Subsequently, Mr. Clardy furnished the information which appears on p. 147.]

Senator DECONCINI. Mr. Brest, do you have anything you want to add to your commander's statement?

Mr. BREST. Yes, sir, I do.

There was, early on, testimony by Richard Miller, the region 7 director, I believe it is, and he brought out some statistics which do not coincide with others that you may have been provided with.

And as was stated in the statement by Lencho Othon, the commander, that we'd like to have further investigation in this and also, if it is deemed proper and necessary to have surgery there, that proper funding and staffing be made available, which I'm sure you will do. That's basically all I have on the surgery.

Regarding the Vet Centers, we found them helpful in our claims with the Department of Veterans' Benefits at the regional office, wherein a claim may have been denied based on lack of evidence.

However, development was made and some claims are allowed based on that evidence. We thank them for that support. That's all I have, sir.

Senator DECONCINI. On the survey that you've shared with us on the Prescott, how was that survey conducted, Mr. Brest?

Mr. BREST. Sir, a representative, a field service representative, his name was John Viticus, came up to that facility and did a survey for approximately 3 days, and after that he would share that information with me.

Senator DECONCINI. Did he go over the logs and the records there? Was that accessible to him?

Mr. BREST. Yes, it was, sir; and I believe you do have that as a copy.

Senator DECONCINI. Yes, we do, and as you heard the testimony this morning, Mr. Miller disputes that based on their survey, going to the hospital and reviewing the logs and the records there.

Mr. BREST. Well, that's why I say it seems that there is a—not to use a strong word, but glaring—a glaring inconsistency which I believe needs to be looked into.

Senator DECONCINI. I should say there is. Yes, we're going to look into it. I just wanted to get it on the record of how you, The American Legion, conducted your survey and analysis.

We welcome that. That's the basis for—as well as other information that's been brought to our attention—the basis for our objection to this and to turn this thing around, and hopefully, the VFW, when they have a chance to do their survey, maybe that substantiates the inaccuracies of the VA's own system. I think the deck was stacked against us before and is presently stacked against us, and that is why we are getting the short end right here in Arizona. That bothers me a great deal.

Mr. BREST. Sir, something else that bothers me, that gnaws at me at times, is the fact about nursing home care.

That's something—you know, mention before was made about counseling made to a person as to getting a divorce. That hurts me. It grieves me to think that would be happening.

Senator DECONCINI. I want to get back to that subject matter but I don't want to forget Mr. Smith. Do you have any information you want to add, Mr. Smith?

Mr. SMITH. No, sir, I don't; just that I'd like to thank the committee for inviting me here today.

Senator DECONCINI. Glad to have you here. Let me ask you on that question, you may have heard my question to the director of the Phoenix hospital here, Medical Center, regarding counseling from social workers at the Center. Have you ever heard of a social worker advising a spouse to take legal action to sever their marital relations with a veteran to establish a county and State indigent care eligibility?

Mr. BREST. Sir, I've heard intimations made from wives of seriously disabled non-service-connected persons who are in the VA Medical Center or on a contract basis, and they are, from what I understand—and they asked me to do this on a confidential basis—that they're told that they have too much real estate or whatever and that becomes a rather delicate situation within the family, because they certainly don't want to sever any relations with this man or woman that they have lived with for many years.

Senator DECONCINI. Mr. Clardy, do you have anything?

Mr. CLARDY. Sir, Mr. Chairman, the only thing I've run into is that the inexperienced social workers working these cases up there, like on a non-service-connected single veteran, have resorted to spend-down tactics to allow him to qualify for county health-care assistance.

Senator DECONCINI. I see.

Mr. CLARDY. And that's the only situations I've run into; but divorce proceedings, I've not run into anything like that.

Senator DECONCINI. Not run into any complaints along that line?

Let me ask you another question. Historically, has access to a community-based nursing home care been a problem to your members?

Mr. CLARDY. I've not run into any problem till here lately. It seems like we don't have any funds left for any community contracts, and that's the only problem I've run into here lately.

Senator DECONCINI. How about you, Mr. Brest.

Mr. BREST. Sir, one problem that I did run into, which was resolved favorably on behalf of the veteran, was that a service-connected, 100 percent service-connected disabled veteran in need of nursing home care, it was wondered if that condition in fact was the true condition which kept him in a nursing home, and initially it was denied to keep him there on an indefinite period.

And that was found to be an arbitrary decision later after the evidence was weighed.

Senator DECONCINI. I cosponsored legislation to prevent spousal impoverishment in the social security system and I'm about ready to extend that to veterans, but I'm glad that it isn't as big a problem as I thought it was.

Do you have any historical information on the community nursing home care problem, Earl, or——

Mr. BOWERS. No; I haven't had anything on it. I imagine that our national service office would and I think Judy could check with Larry on that.

Senator DECONCINI. What do any of you think will be the effects of the reduction of extension time to 45 days from the usual 6 months?

Mr. BOWERS. Well, I've had people who have approached me in the past with regards to the 6-month extension, and I've had many people who were unhappy with the 6-month extension. I think the reduction of 45 days is going to be a disaster as far as persons going into nursing homes. I don't think they should reduce it to 45 days.

Senator DECONCINI. Do you have any comments, Dick?

Mr. SMITH. The sooner that—the membership that we have, when they're required to be put in a nursing home generally—not only in Arizona, but in other parts of the United States—have to be in a VA nursing home because of the chronic medical support that's required for the type of disability that they have.

Normally they're placed in a community nursing home. You find them very quickly returning to the VA hospital because of tissue breakdown or associated problems with the paralysis. So you don't find too many of the paralyzed veterans in community nursing homes for very long.

Senator DECONCINI. I see. Gentlemen, do you have any comment on the 45—on the change to 45 days?

Mr. CLARDY. Yes, sir; we think it would be very disastrous for the non-service-connected veterans out there, because they put them in there for 6 months to give them a chance to be able to cope on their own after the 6-month period, and we work very closely with the hospital directors if anything went beyond the 6-month limit and they were very compassionate on leaving these people in place until everything could be worked out.

Some of them were in there for an additional 6 months. Took that long to work everything out.

You know that the VFW's is on record—they appeared in front of the subcommittee—of the Hospital Affairs' Committee back in May, I think it was, and they asked that that 45 days be rescinded, and we supported that issue of rescinding that 45 days and leaving that with the discretion of the hospital directors for approval of extensions.

Senator DECONCINI. You were figuring they know best, is that correct?

Mr. CLARDY. Right.

Senator DECONCINI. Let me go to another subject matter.

You probably are all familiar with the announcement made recently by the Veterans' Administration that the Department of Defense has located some 10 million medical records dating back to World War II and the Korean war.

What impact do you see of this evaluation on future inquiry levels and subsequent requests for current exams to establish claims of medical care and eligibility?

Let's start with the Legion.

Mr. BREST. Sir, I believe that the recovery or finding of those lost records that were previously told to veterans that they didn't exist is going to be a boon to them in possibly reestablishing a claim, reopening, et cetera; and hopefully, the timeliness in developing and having a VA medical center rating examination will be quickened.

Senator DECONCINI. Any comments on this issue?

Mr. CLARDY. Yes, sir. I feel that the impact is going to be really great here in Arizona, because we have got quite a few of those veterans in those categories identified, of World War II and Korea.

And the only problem we are going to run into is that not every veteran is going to know if he's under that situation, so there's going to be a lot of searching in St. Louis for veterans that are not in that category but a veteran thinks he's in that category, and once he thinks he's there you have got to follow through with the paperwork on it.

Senator DECONCINI. So it's going to cause a lot more paperwork on the VA.

Mr. CLARDY. Right, a lot more paperwork.

Senator DECONCINI. And on your part, too.

Got any comments?

Mr. BOWERS. Yes, Mr. Chairman.

We have been working for a number of years trying to help veterans who were shafted under the 1950 rule where they were reduced from 100 percent down to 50 to 30 to 20 percent. We have a lot of those people in our State right here.

There's no way that these people can ever be reevaluated and get back that 100 percent that they lost. There are a great many of them who would love to get back even 50 percent to break even, with their age and their social security and so forth.

I don't know if you recall, Senator, but about 1980 or 1981, I believe it was, I sent a letter to you with regards to records that were supposed to have been located in Indiana on microfilm, and you had passed that on to the Pentagon and I received a letter—which I had out about a month ago—from a colonel in the Pentagon who said that they could establish a disability, or help establish a disability, if the individual knew what day that it happened, what his organization was and so forth, by going back and checking the morning report.

Well, we tried to follow up on that situation. That turned out to be a dud, too. Now, if the Pentagon says that they have a mass of records where they could help disabled veterans, then I think this would be the greatest thing that ever happened, due to the fact

that those guys who got the shaft in 1950 from 100 percent to 30 percent will now have a chance to get reevaluated based on that disability and at least come back to 50 percent, if it would help them——

Senator DECONCINI. Sure.

Mr. BOWERS. So I certainly think it would be a help to the disabled veterans if they can find those records, but I doubt that very seriously because everybody else has denied it, including St. Louis, where the records were supposed to have been burned.

So I think it would be great if they could find those.

Senator DECONCINI. Do you have any comments?

Mr. PELKEY. I assist the DAV hospital service officer in Prescott 2 days a week. We've already had a number of inquiries about it.

It'll mean a lot of paperwork for both St. Louis, the records center, and service officers in general.

Senator DECONCINI. Dick, do you have—when you respond too, Dick, do you have any suggestions on should Congress get involved in this to see that these records are preserved or something is done with them?

Mr. HOOVER. Yes, sir; I think they should, and let me say this is an issue that comes very close to home; actually in home for me. My father was in artillery in World War II, and when he was discharged he had noted on his medical records that he had a hearing loss as a result of that.

He's now retired and his hearing has become worse and worse as a result of his service, and all he wants is a hearing aid. He lives in Idaho and he's unable to get a hearing aid because the VA indicates that his records fall within that group that are lost, and so they are placing the burden of responsibility of finding records that are over 45 or 48 years old on him to prove that indeed, when he was discharged, there was a medical deficiency in his hearing.

I think it's unconscionable for the VA to take that position.

Senator DECONCINI. I do too.

Mr. HOOVER. But he's pursued that and we're now 2 years into a paperwork process of simply trying to get a hearing aid for him.

Senator DECONCINI. Do you think—any of you think that there's a role that Congress can play regarding these 10 million medical records? Should we attempt to do anything with them or do you have any suggestions?

Mr. BOWERS. I would suggest these people that got the shaft in 1950—and a lot of them are my good friends, and I—like I told you once before, I'm a disabled veteran's advocate and I'd go all the way to hell and take on the devil if I knew it was going to enhance the plight of any disabled veteran.

I think what we should do is pursue all of those records and see if somehow we can't get some of these people re-established at a higher disability rate, because they were cut from 100 percent back to 50, 20, and 30 percent back in the 1950's.

Senator DECONCINI. What worries me about that is that when you see the OMB and the VA budget being cut because of monetary problems—you know, we can increase foreign aid and increase SDI and do a lot of other things, but we still have every year a cut in the medical care part of the VA budget—I'm very suspicious that there's going to be—there may be some abuse of these records,

because the chances are they're going to help substantiate greater disability and that means more payments, does it not?

Mr. BOWERS. It's a possibility; also retroactive and what have you. It's a possibility, but if we're going to give the veteran a fair shake for going out and putting his life on the line and getting his limbs blown off and coming back with one eye and——

Senator DECONCINI. Oh, what I want to do is——

Mr. BOWERS. I think we better take a shot at giving the veteran that benefit of the doubt, rather than have some—send this money down to Nicaragua so they can blow some more people apart down there. The hell with Nicaragua. Let's take care of what we got at home.

Senator DECONCINI. I agree.

Mr. MAYNARD. Mr. Chairman?

Senator DECONCINI. Yes, Mr. Maynard.

Mr. MAYNARD. I think its about time that the Senate and House got together and agreed on something and told those people in the administration there to keep their hands off of those——

Senator DECONCINI. Yes, that's what I'm trying——

Mr. MAYNARD [continuing]. Microfilm records and that they are available to the veteran.

Senator DECONCINI. That's what I'm trying to pursue; if you have got any suggestions on what we should do. Maybe we should have somebody take them or control them or what have you. I'm a little worried about it. I really am.

Mr. CLARDY. Mr. Chairman, what I suggest that this committee do is make forth a direction to the Veterans' Administration that they lay forth a way to obtain this information.

In other words, are these things filed by name, alphabetically, serial numbers or disability or hospitals? How are they filed?

How are we going to pull this information out of these 10 million records to assist those veterans looking for it? We need some guidelines, and that will cut down a lot of paperwork if we can get some guidelines.

Senator DECONCINI. Good suggestion.

Gentlemen, I want to thank you very much. I could go on here for a long time. I've got a lot of questions and we don't seem to ever get to the bottom of these problems, but your testimony has been very helpful.

Dick, I know that—Hoover—that you've been involved with the Governor's Task Force or Board on Handicapped Accessibility, what have you.

Can you just quickly, for the record, what design changes do you believe are most essential in order to make the nursing home, or any other VA facility, handicapped accessible?

Mr. HOOVER. The issue primarily orients itself around accessibility of the nursing home rooms for people in wheelchairs.

Now, if you look at who is ultimately going to end up in the nursing home, it's going to be the elderly, disabled, or the severely disabled, as I mentioned earlier.

We have—in membership there was a gentleman's understanding, so to speak, when this prototype issued originally came up, that there would be no objection if there was a study done to deter-

mine whether or not what the VA proposed was an accessible nursing home was indeed done.

That study has not been done, and as I indicated in the submitted testimony, it looks like there is no intent to do that.

I would recommend, sir, that the VA be instructed, if your committee and the House can make them do it, to indeed go back and sit down with the original participants in that group that was involved in the nursing home design, and force them to come up with an agreement that's acceptable for a new footprint for those rooms.

As it stands now, people who are unable to get out of the wheelchair cannot get into the water closet, as architects call it, or the stool as the rest of us call it, without assistance, even somebody who has good upper body strength.

That shows very poor design from the outset, and I think they've got to be forced to go back. Retrofitting is tremendously expensive, and as I mentioned, we're involved in it potentially in Tucson; and if we pursue this issue with the State veterans' home here in Arizona—which very likely will be in Phoenix—unless that footprint's changed we are going to end up going back and have to retrofit. It doesn't comply with ANSI standards and any other standards that we have.

Senator DECONCINI. Thank you.

Gentlemen, thank you very much. I appreciate your testimony and we will look forward to working with your organizations in the future.

I do want to make note for the record Mr. Tony Valenzuela is here from the Labor Department, the veteran's office there.

That will conclude the testimony.

Mr. MCGOWAN. Senator, are you taking any testimony from veterans from the community, because I would like to say something specifically about vet center services in Maricopa County.

Senator DECONCINI. I'll be glad to stay as soon as I finish here.

Mr. MCGOWAN. Thank you.

Senator DECONCINI. Gentlemen, thank you very much. That will conclude the panel of witnesses that we have today.

Mr. BOWERS. Thank you, Mr. Chairman.

Senator DECONCINI. Appreciate your time.

[The hearing was concluded at 12:30 p.m.]

APPENDIX

HEARINGS

SENATE VETERANS AFFAIRS COMMITTEE

July 5, 1988

Statement from

RICHARD P. MILLER

Director, Southwestern Region

Department of Medicine and Surgery

Veterans Administration

Southwestern Regional Office
Veterans Administration
1901 N. Hwy 360, Suite 350
Grand Prairie, Texas 75050

Thank you for the opportunity to appear before this committee and discuss the access to Veterans Administration Health Care of the Arizona veterans.

The Southwestern Region of the Veterans Administration's Department of Medicine and Surgery covers a six state area including Arizona, New Mexico, Texas, Oklahoma, Arkansas, and Louisiana. There are approximately 3.5 million veterans residing within the geographical boundaries of the Southwestern Region. In serving the health care needs of these veterans, the Southwestern Region has 21 VA Medical Centers and one independent VA Outpatient Clinic. The Region has an annual operating budget of $1.218 billion and has just under 25,000 VA employees. As a result, each year 209,000 inpatients are treated in regional facilities as well as 2,740,000 outpatient visits. The Region is divided into three Medical Districts to facilitate planning and sharing of available services. Medical District 19 includes the seven VA Medical Centers in Louisiana, Arkansas, and Oklahoma. Medical District 20 includes the eight VA Medical Centers in East and Central Texas. Medical District 24 includes seven VA facilities: three VA Medical Centers in Arizona (Phoenix, Prescott, and Tucson), one VA Medical Center in New Mexico (Albuquerque), and two VA Medical Centers and one VA Outpatient Clinic in Texas (VAMC's Amarillo and Big Spring, and VAOPC El Paso).

The three Arizona VA Medical Centers provide health care services to 409,000 veterans. The combined annual operating budgets for these three medical centers is approximately $148 million. There are 2,900 full time equivalent employees at these medical centers and on an annual basis they provide treatment for 25,000 inpatients and 387,000 outpatient visits.

The Southwestern Region was established in June 1985. Prior to that time, the three Arizona VA Medical Centers were a part of the Western Region.

ALLOCATION OF HEALTH CARE RESOURCES

TO VA FACILITIES IN ARIZONA

The Department of Medicine and Surgery has utilized a Resource Allocation Methodology (RAM) in allocating recurring funding during the last four fiscal years. This methodology takes into account the number of inpatients and outpatients each facility treats, the specific diagnosis of the patients treated, and the medical procedures done for each patient and then makes adjustments accordingly in the Medical Center's budget. More funding is allocated to those facilities with higher workload and more severely ill patients. As a result of this methodology, the Phoenix VAMC has consistently been in a positive RAM posture. The Prescott VAMC has been in a positive RAM posture since FY 1987. With management improvements implemented at the Tucson VAMC, that facility will be in a positive RAM posture in FY 1989. In addition to RAM adjustments, additional funding has also been provided for inflationary cost increases. Overall, the recurring operating budgets for the Arizona VAMC's have increased 11.1% from FY 1986 to FY 1988. At this time, we do not know the final allocation of the FY 1989 budget.

Additional funding has also been provided as a result of initiatives identified through the Medical District Initiated Program Planning (MEDIPP) process. In FY 1987, $4,614,949 was made available to the Southwestern Region for 21 MEDIPP initiatives. Of this amount the Phoenix VAMC received $328,000 to implement Community Residential Care, $125,000 to increase oncology outpatient visits, and $70,000 to increase outpatient visits. This process continued in FY 1988 with $4,598,286 for 14 initiatives being funded in the Southwestern Region. Of this amount, the Phoenix VAMC received $205,000 to establish ambulatory surgery; the Tucson VAMC received $400,000 to establish a six-bed step down intensive care unit and $90,000 to increase cardiac surgery.

Since FY 1986, $4.8 million has been allocated to the Arizona VAMC's for replacement and additional equipment. Another $5 million was provided to the Arizona facilities for non-recurring maintenance and repair projects. In addition, there have been sixteen construction projects funded at the Arizona hospitals for $27,427,000.

THE AVAILABILITY OF SURGICAL SERVICES FOR VETERANS RESIDING IN THE PRESCOTT AREA

The VA Department of Medicine and Surgery and the Southwestern Region is concerned about the access to quality patient care for all its veterans. All of the health care needs of our veterans, from acute to extended care, must be considered in light of the aging of our veteran population.

VAMC Prescott's service area includes the five counties which make up the northern half of Arizona, with a veteran population of approximately 39,000. Two other VA Medical Centers are located in Arizona; Phoenix and Tucson. VAMC Prescott is located approximately 95 miles from VAMC Phoenix. The Prescott hospital was built in the early 1930's. In FY 1987, the medical center reported 193 average operating beds, with an average daily census of 112 and an occupancy rate of 58.0%. Almost 73,000 outpatient visits were reported. The medical center employed 459.9 FTEE and had a total budget of nearly $21.5 million. The original hospital function included both acute surgical and medical services until the Medical District, through its planning processes, recommended closing surgery at the facility. Inpatient surgery was halted in August 1986 following the loss of two general surgeons and a urologist and an anesthesiologist. Outpatient surgery was maintained.

The number of inpatient surgical patients being treated at the Prescott VAMC decreased by 50% from FY 1983 to FY 1986. At the same time, the number of surgical patients from the Prescott area being treated at the Phoenix VAMC increased. This included a large number of direct referrals from the Prescott VAMC to Phoenix. At the same time, Prescott VAMC's ambulatory surgeries doubled in line with the health care systems increased emphasis on ambulatory care.

While the number of surgical patients coming to the Phoenix VAMC from the Prescott area has increased, this increase is minimal in view of the Phoenix VAMC's overall surgical workload and has not

resulted in any measurable increases in waiting times for surgical procedures or clinic visits. In addition to veterans transferred to Phoenix, twelve surgical inpatients were transferred to Tucson VAMC in FY 1987. The VA Medical Centers at Phoenix and Tucson, in accordance with patient referral policies in existence throughout the Region, will accept patients immediately from the Prescott VAMC if they are considered to require urgent surgical treatment. If patients are too critical to be transferred to another VA Medical Center, they can be placed in a community hospital at VA expense.

No evidence exists to suggest that major access to care problems have developed at Prescott as the inpatient surgical workload declined and finally ended. Demographic changes are not apparent that would reverse the historical decline in surgical workloads. Referral for surgery to other VAMCs requires additional travel for veterans, however not unusually excessive. Examination of the patient movement and coordination of referrals to other VAMCs do suggest that this could be improved. The Southwestern Region has taken steps to improve the coordination and transportation of surgical patients transferred to Phoenix and Tucson.

In summary, the surgical workloads at Prescott steadily declined since 1983, despite the veteran population increases. These decreases were experienced prior to the unofficial curtailment of surgery in late 1986. Recruiting difficulties are documented from 1983 forward with significant surgeon vacancies apparent from annual reports. Simultaneous increases in surgical workload were experienced at Tucson and Phoenix, without additional delays in their scheduling. Increases in minor surgery procedures at the Prescott VAMC rose significantly from 1985 and 1986 to 1987.

AVAILABILITY AND QUALITY OF COUNSELING AND PSYCHIATRIC SERVICES FOR VIETNAM VETERANS THROUGH VET CENTERS IN ARIZONA, THE INPATIENT PTSD UNIT AT THE PHOENIX VAMC, AND OTHERWISE

The VA operates three Readjustment Counseling Service (RCS) Vet Centers in the State of Arizona designed to provide outreach and counseling to assist Vietnam-era veterans (VEV) to a full and meaningful post-war readjustment to civilian life. The Phoenix Vet Center and the Tucson Vet Center have been in operation since November 1979 and June 1981, respectively, having been among the first vet centers opened nationally in response to the 1979 legislation authorizing the VA to provide readjustment counseling to Vietnam-era veterans. The third vet center located at Prescott was opened in September 1985, and was one of the expansion sites authorized by legislation passed in 1984.

Since its inception, the Phoenix Vet Center team has seen 4,475 veterans and delivered approximately 18,811 professional visits to veterans and their families; the Tucson Vet Center team has seen 3,498 veterans and delivered approximately 11,052 professional visits; and the Prescott Vet Center team has seen 805 veterans and delivered approximately 6,190 professional visits. In addition to its own service delivery, the three vet centers combined administer contract programs at 15 separate locations throughout the State which collectively have delivered 2,400 professional visits in FY 1987.

Each vet center team operates as a small multidisciplinary team, within a community-based setting, and uses a non-medical model for service delivery emphasizing recovery, rehabilitation, and the avoidance of hospitalization. The capacity for professional psychological counseling and mental health service is embedded in a context of general social services to include employment and educational counseling, referral for other needed VA and/or private sector services, and community outreach activities designated to

locate, inform and to engage Vietnam-era veterans and other community factions. Each vet center team represents a cohesive blending of diverse disciplines and backgrounds with high priority given to Vietnam veteran representation. Originally designed to enhance the accessibility of services, the community-based setting has further resulted in an important additional VA preserve in the community and a significant entry point for many veterans to other needed VA services through referral to medical centers and regional offices.

During FY 1987, Readjustment Counseling Service initiated several quality assurance procedures which are now in place and functioning. Among these activities are enhanced clinical collaboration between vet centers and medical centers, utilization of external clinical consultants for provision of case staffing, in addition to internal case review at every vet center, improved procedures for clinical service and oversight within RCS, and the incorporation of RCS into existing DM&S programs such as the Systematic External Review Process (SERP). Vet center staff are now included on DM&S SERP teams which review vet center operations as well as VA Medical Centers.

A sixteen bed post-traumatic stress disorder unit was established at the Phoenix VAMC in April 1985. This unit not only provides treatment for veterans in the Phoenix area, but also receives referrals from the Prescott and Tucson VAMC's. Both of these facilities report good response from the Phoenix VAMC in accepting patients with PTSD and consider this an excellent program. So far, 172 patients have been treated in this program.

Each of the three Arizona VAMC's has a psychiatric bed section which includes alcohol and substance abuse programs. A high percentage of the patients being treated in these programs are Vietnam-era veterans. Each of the three VAMC's also provide outpatient psychiatric care which is available for all veterans including Vietnam-era veterans.

RECRUITMENT AND RETENTION OF NURSING STAFF

The dramatic economic and technological changes in health care are impacting on all health care professions, but have had their most visible impact on nursing. In addition to technological change, the demand for nurses in non-traditional settings has increased with program developments in ambulatory care, home health care, adult day health care, and other specialized programs. The pressure on nurses in medical centers today is tremendous as they care for critically ill and aging patients in technologically complex environments.

This environment and need is reflected by the fact that the nursing FTEE assigned to the three Arizona facilities has increased by 4.7% from FY 1986 to the present time. The current vacancy rate for RN's at the Arizona facilities of 4.3% is consistent with national rates, but it is higher than regional rates, and the high turnover in all categories of nursing personnel is of particular concern.

The VA has continued to attempt to carefully identify and address issues that might be generating dissatisfaction and turnover among its nursing staff. These major issues have been identified by VACO Nursing Service as:

1) the necessity of "floating" to understaffed units and the need to rotate shifts vs. straight shift assignments,
2) inadequate time and monetary support for continuing education, and
3) need for support services including increased computer support.

Other factors identified by facilities as important issues in competing for nursing personnel are policies on outside employment and earnings, competitive health insurance, and child day care facilities.

Recruitment and retention activities are ongoing at each facility to address issues within their control. Nationally, new Saturday premium pay will assist facilities in their recruitment efforts. Special entry pay rates for RNs have been approved at all three facilities and for LPNs in Phoenix. Special salary rate funding for the facilities in excess of $400,000 has been approved in FY 88. Significant tuition support funds have also been provided to each site. We look forward

to working with each site to implement the nursing computer packages as site ADP capacity is upgraded.

In reference to the issue of nursing staffing, each facility assigns staff to units based on patient categories and the distribution of the patients within the facility. As each of these facilities is surveyed by the Joint Commission, the requirement for formal mechanisms to appropriately assign staff based on patient need is reviewed. In their last Joint Commission surveys, the Arizona facilities met with Joint Commission approval in this regard.

Each Medical Center and the Region as a whole are constantly reviewing the status of nursing staffing and developing creative solutions to meet the ever changing issues in recruitment, retention, and staffing. Based on the projections of numbers of nurse trainees by national nursing organizations, we can expect these issues to remain with us for the near future and to exert considerable impact on the role of the nurse and the environment within which nurses work.

ACCESS OF ARIZONA VETERANS TO NURSING HOME CARE, EITHER AT VA FACILITIES OR AT VA EXPENSE

The Phoenix VA Medical Center has a 120-bed VA Nursing Home Care Unit and the Tucson VA Medical Center has a 41-bed Nursing Home Care Unit. Both of these units are filled virtually all of the time. The Veterans Administration is now constructing a 60-bed VA Nursing Home Care Unit at the Prescott VA Medical Center at a cost of $5,444,000. This unit should be completed in May 1989. In addition, a 120-bed VA Nursing Home Care Unit has been funded for construction at the Tucson VA Medical Center in this fiscal year, and the project should be awarded this year with an estimated completion of August 1990.

The three Arizona VAMC's also are funded $7,646,734 to provide veterans with community nursing home care at VA expense. This

has enabled them to maintain a combined average daily census of 307 veterans in community nursing home care through June 1988.

The access of Arizona veterans to community nursing home care is complicated by the fact that Arizona does not have Medicaid available. However, in October 1988, the Arizona Health Care Cost Containment System (AHCCS) will asume responsibility for funding long term care. This would be available only to individuals with a monthly income of less than $1062.

This concludes my statement. I would be pleased to address any questions you may have.

STATEMENT OF ALPONSO ESTRADA, JR.

DIRECTOR, VETERANS ADMINISTRATION MEDICAL CENTER

BEFORE THE

SENATE COMMITTEE ON VETERANS AFFAIRS

JULY 5, 1988

I am honored today to be asked to represent the Prescott Veterans Administration Medical Center before this distinguished committee. I request that the committee members, upon hearing my testimony, take into consideration the fact that I have just recently been appointed Director at the Prescott facility. As a result, I have no first hand knowledge of access to health care for Arizona veterans. My thirty years of federal service, with the last twenty-five in the Veterans Administration, I believe, does qualify me to present views on veteran health care issues. In response to the committee's request, my staff has compiled some information regarding the five specific areas addressed in your letter. I welcome the opportunity to share this information with you.

Allocation of Health Care Resources

The budgeted allocation for VAMC Prescott has risen from $18.2 million in FY 84 to $21.6 million in FY 88. These funds overall have been adequate to meet operating needs of the facility. There are, however, several existing areas where sufficient funding is a concern. As an example, our station equipment money has seen a reduction from a high of $358,000 FY 85 to $162,000 FY 88. There are several pending equipment requests due to lack of funds. The most crucial item is replacement Radiology equipment costing $500,000. The Regional Director's office is aware of this need and is assisting us in locating resources. Other areas of concern include adequate funds for non-VA CAT scans and contract non-VA hospitalization. The use of CAT scans has become the accepted standard of care for diagnosis of many medical conditions. The use of VAMC Phoenix as a resource for CAT scans for our patients is limited to eight patients per month due to their workloads and priorities. Therefore, some services must be purchased from the local community hospital. The number of referrals has been greatly reduced in order to stay within our fiscal limitations. In addition, with closure of our surgical program there has been a need to utilize non-VA community hospitals in emergent situations. Both of these areas require close monitoring to assure appropriate and efficient use of funds. For the committee's information, I have included additional fiscal and workload information:

Budget Allocation

FY 84	FY 85	FY 86	FY 87	FY 88
$18.2 mil	$18.9 mil	$20.6 mil	$21.4 mil	$21.6 mil

2.

Workload

	FY 84	FY 85	FY 86	FY 87	FY 88*
Hospital					
Avg Daily Census	135	122	100	112	104
Pts Treated	3464	3366	3286	3219	3400
Domiciliary					
Avg Daily Census	130	168	187	196	195
Outpatient					
Visits	52,422	46,925	55,348	72,903	75,800

*Projected figures for FY 88

Availability of Surgical Services

As the committee is aware, an initiative was introduced and accepted through the Fiscal Year 1986 MEDIPP process to deactivate the inpatient surgical program at Prescott VAMC. Over the past several years the inpatient workload has decreased to no services available at Prescott VAMC. Our medical center has taken steps toward the enhancement of our Ambulatory Care Program and the Domiciliary program. A new 208-bed Domiciliary is scheduled to start construction within the next few months. In addition, a new 20-bed Intermediate Medical Care Unit has been activated.

The issue of resuming surgical services has been addressed by several task forces and at the District and Regional Office levels. One of my primary goals is to maintain effective working relationships with the management officials of Phoenix and Tucson VAMCs. I have already contacted Mr. Ray Bourne, Director, VAMC Phoenix, and Mr. Jerry Boyd, Director, VAMC Tucson, and both have expressed a willingness to fully cooperate in providing timely access to all services for our veterans. I am confident that we will address and resolve any existing or potential problems.

Availability and Quality of Counseling and Psychiatric Services for Viet Nam Veterans

VAMC Prescott offers inpatient, outpatient and domiciliary services to all eligible veterans, including Viet Nam veterans. During FY 1987 a total of 740 Viet Nam Era patients were seen in our Outpatient Department generating 6,626 outpatient visits. Six hundred twenty-nine Viet Nam Era veterans were admitted to our hospital for inpatient and domiciliary care. Alcohol Dependency Treatment Program has approximately 430 patients a year attend their program. Many of these veterans are from the Viet Nam era. Outpatient psychiatric services are also provided at our facility. An active Vet Center is located in the city of Prescott. Relationships between the Medical Center and the Vet Center are good. The Vet Center continues to see approximately eighteen new cases a month, indicating a continuing need for these services. I will defer further comments on this topic to the testimony of the Vet Center Team Leader, Richard Wamboldt.

3.

Recruitment and Retention of Nurses

Fortunately, VAMC Prescott has not seen the full impact of the nursing shortage experienced by other facilities. However, recently there have been signs that indicate our facility is being affected. Several nurses have left VA employment for better pay and more flexible tours of duty in the Phoenix area. We were recently approved for special pay rates for nurses which will help us remain competitive. We have already seen the positive results of this action through statements by several recent hires and several nursing staff who elected to remain with us. There have been peaks and valleys with our recruitment efforts. Of some concern to us are potential recruitment problems in achieving adequate staffing levels for our new Nursing Home Care Unit scheduled for completion June 1989. An additional 40 nursing personnel will be required for full activation of this unit. Availability of this many qualified personnel will be a concern.

Access to Nursing Home Care

The VAMC Prescott's primary service area has the fastest growing population over the age of 65 in the Medical District. Current demands for nursing home care are being met through contract community nursing home care. Future plans call for completion of a sixty-bed Nursing Home Care Unit at the VAMC Prescott in June 1989. This facility will be constructed so that an additional sixty beds may be added at a future date. The current average daily census for community contract nursing home is 56. Generally, funds have been adequate to maintain this census though there are times when there have been delays in placement of patients due to shortages of funds. Of concern in Prescott is the fact that Arizona does not participate in the Medicaid Program, applicants to AHCCS must "spend down" to receive benefits. This often produces hardships for veterans' families.

Summary

In conclusion, I would like to state that in the short time I have been at VAMC Prescott I have witnessed a hard working, dedicated and sensitive work force. Many patients, volunteers and members of veterans service organizations have expressed to me their appreciation for the care they and other veterans have received at our facility. I look forward to the challenge of continuing this tradition of quality service at VAMC Prescott; and I accept the challenge to utilize the full potential of the fine Medical Center personnel to become even more efficient in the delivery of health care to Arizona veterans. Thank you for the opportunity to meet with you this morning.

HEARING

SENATE VETERANS AFFAIRS COMMITTEE

JULY 5, 1988

STATEMENT FROM RAY L. BOURNE

DIRECTOR, CARL T. HAYDEN VETERANS ADMINISTRATION MEDICAL CENTER

SEVENTH STREET & INDIAN SCHOOL ROAD

PHOENIX, ARIZONA

Thank you for the opportunity to present our assessment of access to care for veterans.

As the veteran population has dramatically increased, so has the demand for services. Our ability to keep pace with demand has lagged. Our physical facilities, while upgraded in 1975 with a large bed addition, did not predict the huge population increase nor the aging veteran population which came with the growth. We have, in the planning process, adequate facilities to meet the current and future needs of veterans in central Arizona. However, that plan must be vigorously pursued if we are to meet the veterans' needs.

A resource allocation methodology (RAM) has been in use for the past five years. This process links workload, patient severity indices and budgets. Simply stated, the process directs resources to those facilities where there are active patient treatment programs. As a result, we have each year received additional funds that partially reflect the growing patient activity at this medical center. We are hopeful the RAM process will mature to its full potential to provide full funding for services provided.

The Veterans Outreach Center at Phoenix is one of the first such facilities established. As a result it has had the time and opportunity to grow and to refine its services to veterans. It has stabilized its services to a defined population and provides high quality, timely service. A close working arrangement has developed between the outreach staff and the staff of the Psychiatric Service at this medical center.

The Post-traumatic Stress Disorder Unit, consisting of sixteen beds, was established in April 1985. This service was in partial recognition that a significant number of veterans needed a specialized and definitive course of treatment that was not always available through traditional psychiatry. To date we have treated over 172 veterans. As a result of the knowledge gained in this treatment modality, we are becoming aware that a larger veteran population than we previously thought may benefit from this therapy.

The services of outreach counseling, inpatient and outpatient psychiatry and an active Post-traumatic Stress Disorder Unit, are responding adequately to the psychiatric needs of the veterans. As noted, the PTSD Unit has and always had patients awaiting admission.

The shortage of registered nurses is to a degree cyclical in Central Arizona. This is caused by the influx of winter visitors which swells the bed occupancy of the private hospitals. We have instituted special pay provisions, Saturday premium pay, an aggressive advertising and recruiting program, and are still not able to fill all of the vacant positions at our medical center. While the number of vacant positions during the summer months are lower, it is expected these nursing vacancies will increase this winter.

The provision of surgical services to veterans residing in the Prescott area has been extensively studied by staff at the District level and by groups outside the District. The plan for surgery does not deviate

significantly from the level of services historically available. Essentially, the plan provides for the Phoenix and Tucson medical centers to be the referral centers with Prescott continuing to perform outpatient surgical procedures. This provides timely, high quality surgery for those patients requiring more complex procedures and cost effective, timely service to those veterans whose surgical needs can be accomplished at Prescott.

We are experiencing a gradual increase in demand for nursing home placement. Our VA Nursing Home has maintained a full-bed occupancy, so by necessity, placement takes place in the community nursing homes. We have requested an increase of 11 community nursing home census for the remainder of this fiscal year. Our assigned census of 120 is barely adequate and we will see a need for that census to increase as the peak demand for World War II veterans occurs.

In summation, access to care by our veterans is directly impacted by the swift growth in demand and a less rapidly changing facility. We need to continue the efforts to balance our ability to provide service with the needs of our veterans.

STATEMENT OF

JERRY R. BOYD
MEDICAL CENTER DIRECTOR

ALFRED HEILBRUNN, M.D.
CHIEF OF STAFF

VETERANS ADMINISTRATION
MEDICAL CENTER
TUCSON, ARIZONA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

July 5, 1988

Mr. Chairman and Members of the Committee:

Good morning. This statement represents the views of both the Medical Center Director and its Chief of Staff. We are pleased to have the opportunity to appear before this Committee for the purpose of reporting to you on the access of Arizona veterans to Veterans Administration health care. I report to you as the Medical Center Director of 11 months at the Tucson Veterans Administration Medical Center.

RECRUITMENT AND RETENTION OF NURSES AND ADVOCACY OF STAFFING LEVELS

Since being employed by the Veterans Administration Department of Medicine and Surgery, approximately eighteen (18) years ago, for reasons unexplained or unknown to me, the nation's health care delivery system, including both the public and private sector, has experienced a serious nursing shortage at five year intervals. The first shortage came in 1971; then another in 1976; another in 1981; and, the current one beginning in 1985 and lasting until the present time.

Each of the shortage cycles has been more severe than the previous one and the current one is worse than any to date. The current literature contains copious theories and explanations for the nursing shortage which will not be expanded on in this testimony.

2.

In particular the VA nursing shortage seems to vary in severity among the different geographical areas of the country. Having served as the Director of the Boston (Jamaica Plain) VA Medical Center prior to becoming the Director at the Tucson VA Medical Center, I know that the Nursing shortage is much more severe in the Northeast than at the Tucson VA Medical Center; and the nursing salaries at the Boston VA Medical Center are approximately five to eight thousand a year more than at Tucson.

Recruitment and Retention of nurses at the Tucson VA Medical Center has become increasingly more difficult over the past three years. RN turnover rate in 1985 was 17%, 1986 - 20%, and 1987 - 26%.

The nursing shortage at the Tucson VA Medical Center is primarily confined to the Critical Care Units as opposed to the ward staff nurse positions. The Critical Care Unit nurse is subjected to a much more intense level of stress due to the severity of the patient cared for. "Nurse Burnout" is not uncommon in these units. Therefore, most nurses choose to work in a less stressful environment on the wards.

Our salary structure at the Tucson VA Medical Center approximates the salaries paid in the community except for our entry level nurses, since our rates cannot exceed those paid by the community when requesting and justifying special rates. However, VACO has been very supportive and prompt in granting our special rate requests. I personally believe there are alternatives in solving the nursing shortage problem than merely throwing more money at the issue. Many areas must be explored to make the Nursing Profession more attractive to the young person seeking a rewarding and satisfying career.

Working evenings, nights and weekends continues to be an obstacle in recruitment and retention of nurses. The differential for evenings seems to be adequate. Recently implemented Saturday pay should improve the acceptability of working weekends. However, the night tour-of-duty continues to present a problem at the Tucson VA Medical Center. The differential for nights should be greater than evenings since nights are more difficult to staff. The private sector does distinguish between evenings and nights paying up to a 15% differential for nights.

The Tucson VA Medical Center has seen a dramatic change in the health care picture over the past three years. Nursing care requirements are determined by length of hospital stay, and patient classification (Category I, II, III, IV -- Category I requires the least care and Category IV requires the most care).

3.

	1985	1986	1987
Length of Stay	11.6	10.3	7.8
% of Category III & IV patients	31.0%	36.0	50.0%

These figures translate to very sick patients staying shorter periods of time. In other words, every day counts and the nursing care requirements each day are increasing along with technological advances.

Recruitment of nurses is steady but does not keep pace with the demand. New graduates and medical-surgical nurses do apply for positions with us. Experienced critical care nurses are very difficult to recruit.

In light of the nursing deficits, the quality of care delivered is excellent. The Tucson VA Medical Center has a particularly dedicated nursing staff who have thus far risen to the expectations. To maintain the high quality of care delivered by the nursing staff our goals are to:

1. To establish and maintain nurse staffing levels based on patient care requirements;

2. Establish nurse salaries at a level competitive with the private sector and revise salary scales to reward the long standing employee;

3. Establish an adequate shift differential to recruit and retain nurses on the night tour-of-duty, and;

4. Provide an adequate tuition support for all nursing staff.

More flexibility in pay and benefits should be provided to local management to successfully compete for the available nurses in the community. The flexibility should be granted in those areas where the most difficulty is encountered; i.e., weekends, holidays, nights, Critical Care areas, etc.

The laws of supply and demand are currently controlling nursing recruitment and retention. Nurses are very much aware that they are a scarce commodity. We are using every option available at the Tucson VA Medical Center to assist in a competent and adequate nursing staff to meet the needs of our veteran patients and to insure that the highest level of quality care is provided.

4.

AVAILABILITY AND QUALITY OF COUNSELING AND PSYCHIATRIC SERVICES

FOR THE VIETNAM VETERANS THROUGH VET CENTERS IN ARIZONA

QUALITY

During the past several years there has been a concerted effort to professionalize the Vet Centers, i.e., to link the Vet Center staff to one of the main professions within the VA: Social Work Service, Psychology, Nursing, or Psychiatry Service.

The Tucson Vet Center staff has a good mixture of professional training and military experience. Three of the four staff are Vietnam veterans, two having served in Vietnam, the other in the Phillipines. The Team Leader was a pilot. Another was a physician's assistant with the medics. The Team Leader is a highly qualified individual. He has worked as a counselor at the Phoenix Vet Center prior to coming to the Tucson Vet Center in 1981. He later served as Assistant Regional Manager in Providence, Rhode Island. When he recently returned to his former job as Team Leader at the Tucson Vet Center, he brought with him a national perspective regarding the problems of Vietnam veterans.

AVAILABILITY

The Vet Center is centrally located in a small, comfortable building near Speedway and Swan. The usual office hours are 8:30 a.m. to 5:00 p.m., with the office remaining open two nights a week until 9:00 p.m.

Services at the Vet Center are responsive to client needs. In addition to the counselling services, a representative from the Department of Labor is available to assist with employment problems.

For veterans who do not live close to Tucson, there are contract services available with agencies in Casa Grande, Yuma, and Nogales. Vet Center and VA Medical Center staff try to maintain a close liaison with the community health agencies. Recently, a joint team from the Vet Center and the VA Medical Center visited the mental health agency in Nogales to give a training session on PTSD and to explain services available at the Vet Center and the VA Medical Center.

VET CENTER - VA MEDICAL CENTER LIAISON

Close ties have been established between the Vet Center and the VA Medical Center. A staff member from the Vet Center visits the inpatient psychiatric ward once a week to meet with hospitalized Vietnam veterans. These weekly meetings provide the staff member an opportunity to meet with veterans he has worked with on an outpatient status, as well as to invite veterans who have never been to the Vet Center to become involved in the services.

5.

For several years there has been a Wednesday evening Vietnam group at the Medical Center, with the Psychiatry head nurse and a Vet Center staff as co-leaders. The group is open to both inpatients and outpatients. Attendance ranges from eight to twenty veterans per week. Other Vietnam Veteran groups at the VA Medical Center include a combat group at 1:00 p.m. on Friday and an Ex-POW group on Monday evenings. These two groups are open to appropriate veterans from other wars, also.

Social Work Service is providing ongoing consultation to the Vet Center, as requested by the Regional Manager of the Vet Center in Dallas. Three of the VA staff alternate in providing monthly consultation regarding documentation, treatment plan review, and other case consultations. The Family Mental Health Coordinator at the Medical Center is a primary staff person providing consultation. He has also made available to Vet Center staff participation in the weekly family Mental Health seminars. Since domestic problems are often associated with Vietnam veteran clientele, the Family Mental Health services are often a needed service.

If a veteran who is seen at the Vet Center is in need of acute psychiatric care, there exists easy access between the Vet Center Staff and Mental Hygiene Clinic staff for psychiatric admission screening. This referral process works both ways, as Vietnam veterans being discharged from the hospital are often referred to the Vet Center as an important part of the discharge plan.

VIETNAM VETERANS AT THE MEDICAL CENTER

The Homeless Chronically Mentally Ill (HCMI) and the Alcohol Treatment Unit are two VA programs that have a high Vietnam veteran representation. Of the 856 homeless veterans seen during the past year, 397 (46%) were Vietnam Era veterans. Over 50% of these veterans had combat experience. During the past decade the Alcohol Program has shown a steady increase in the number of Vietnam Era veterans. The treatment program has now evolved to a polysubstance abuse format, with many of the veterans having problems with both alcohol and drugs. Over 52% of the Alcohol Treatment Unit patients are Vietnam Era veterans.

PTSD - PHOENIX VA

The PTSD Program at the Phoenix VA Medical Center has provided excellent services for our Tucson veterans. Referrals are thoroughly evaluated, prompt feedback is given to the one making the referral, and the program has been effective in working with these veterans.

6.

CONTINUING EDUCATION

During the past year Social Work Service and the Vet Center staff sponsored a series of four programs dealing with the various programs of Vietnam veterans and their families. These programs were well attended both by VA Medical Center staff and mental health workers from various community agencies. In addition there was cooperation between the Vet Center, the VA Medical Center staff, and the Vietnam Veterans of America in sponsoring the successful Nam Jam.

SUMMARY

My impression is that the quality and availability of services to Vietnam veterans and their families has steadily improved over the past several years. Part of the improved services is due to the close liaison between staff at the Vet Center and at the VA Medical Center. We are looking forward to more areas of mutual involvement between the Vet Center and the VA Medical Center.

THE ACCESS OF ARIZONA VETERANS TO NURSING HOME CARE EITHER AT VA FACILITIES OR AT VA EXPENSE

NURSING HOME CARE UNIT (NHCU)

The NHCU is a 41-bed unit, consisting of a majority of total care patients. Application to the NHCU can be made either by inpatients or outpatients. Priority in admissions is given to service-connected veterans. Because of the complex level of care provided to the NHCU patients, there is a low turnover rate in the unit. A new 120-bed NHCU has been approved and funded to replace the current facility with groundbreaking due in the Fall of this year.

CONTRACT NURSING HOME (CNH)

There has been a marked increase in the demand for nursing home placement services over the past decade. In 1980 the contract census was 56. During the current year there have been as many as 130 veterans in contract placement.

The Tucson VA Medical Center contracts with eleven nursing homes in the metropolitan Tucson area, and eight rural nursing homes, including homes in Douglas, Green Valley, Yuma, Sierra Vista, Benson, Safford, and Lordsburg, New Mexico. All of the homes are inspected by a VA health care team. Veterans placed in community nursing homes are followed by a VA social worker and a community

7.

health nurse. For veterans in rural Arizona it is especially important to have contract nursing homes located in their community, as family and friends are better able to visit, than if placement were in Tucson.

The quality of care provided by the nursing homes is of a high level. Some of the homes specialize in services to Alzheimer - patients, and have wards that are especially adapted for patients that wander. Five of the nursing homes provide rehabilitation services (physical therapy, speech therapy) at no additional cost.

TERMINATION OF CONTRACT

Since the VA contract is limited to six months for nonservice-connected veterans, it is important that an alternative plan be developed for the end of the placement. In Tucson we have been fortunate that Pima County Aging and Medical Services has been able to provide long term care services to eligible veterans. In October 1988 Arizona Health Care Cost Containment System (AHCCS) will assume responsibility for funding long term care. One of our concerns is that the new system will create a larger "notch group" that will be ineligible for needed nursing home placement. Under AHCCS a person with an income of over $1762 would be considered ineligible, despite the fact that the average monthly cost for nursing home care ranges from $1800-2000. Hopefully, Arizona will adopt legislation similar to other States utilizing Medicaid, which would allow the amount of medical expenses spent to be subtracted from accountable income.

SUMMARY

The Contract Nursing Home Program has expanded 100% in the past eight years. We have quality nursing homes available both in the Tucson metropolitan area and throughout the State. We continue to look for new contract facilities, and have added eight new homes during the past two years, bringing our total number of contracts to 14. We will continue with our commitment to meet the needs of the aged veterans. An important part of that commitment is the availability of a quality Contract Nursing Home Program.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of this Committee may have.

HEARING

SENATE VETERANS AFFAIRS COMMITTEE

JULY 5, 1988

STATEMENT FROM LUIS GARCIA-BUNUEL, M.D.

CHIEF OF STAFF, CARL T. HAYDEN VETERANS ADMINISTRATION MEDICAL CENTER

SEVENTH STREET & INDIAN SCHOOL ROAD

PHOENIX, ARIZONA

HEARING

SENATE VETERANS AFFAIRS COMMITTEE

Thank you for the opportunity to present my assessment on access of Arizona veterans to Veterans Administration health care.

The state of Arizona and the Phoenix metropolitan area in particular have been among the fastest growing in the recent years and this has been reflected by a similar growth of the veteran population. The Phoenix VA Medical Center's primary service area encompasses Maricopa and Gila counties and, at the present time, it is the primary residency site for 240,000 veterans. In addition to this permanent population, the Phoenix metropolitan area experiences a large influx of veterans from colder climates during the winter months, and this is reflected in a marked seasonal increase in the Medical Center's workload.

The same climate conditions make Arizona more attractive for retirees, either as a permanent residence or as a temporary one in winter and, as a result, the average age of veterans in this area tends to be more advanced than in other regions of the country. Of the 240,000 veterans residing in the Phoenix primary service area at the present time, nearly 60,000 are 65 years or older, which represents a twofold increase for this age group in the last six years.

The increasing age of the veteran population has been paralleled by an increase in the complexity and multiplicity of their medical problems. This has placed demands on resources in addition to those created by the continuously increasing number of veterans being served. Workload statistics for the last three years at the Phoenix VA Medical Center are illustrative of these increases.

FISCAL YEAR	NUMBER OF OUTPATIENT VISITS	NUMBER OF INPATIENTS TREATED
1986	142,900	11,991
1987	161,300 (+11%)	12,889 (+7%)
1988 (Projected)	190,000 (+15%)	14,560 (+11.5%)

The resource allocation methodology (RAM) has been gradually introduced in the VA system for the past four years. This method recognizes workload and

productivity, and channels funding to the various VA Medical Centers accordingly. Under RAM, our funding has gradually increased for the past few years helping to meet the growing needs for patient care. A capping process applied to funding under RAM keeps some of our needs from being fully met, particularly during the more active winter months, but the capping process is a temporary measure which will ultimately be removed when RAM has achieved full implementation.

The Phoenix VA Medical Center has made its services fully available to the veterans residing in the Prescott area. Although a majority of referrals from Prescott are for surgical services, Phoenix also absorbs most of their oncology cases as well as other medical problems of greater complexity. Elective surgery cases from Prescott are placed on the same general schedule as Phoenix patients. Physician to physician contact between Prescott and Phoenix allows prompt intervention in the more urgent case.

Counseling and psychiatric services for Vietnam veterans is available through the regular inpatient psychiatric services and mental hygiene clinic. The vet centers have proven very helpful for those patients requiring a more individualized approach and they have oriented their efforts towards outreach programs with great success. The Veterans Outreach Center at Phoenix was one of the first ones to be created and works in close cooperation with the staff of the Phoenix VA Psychiatry Service.

The Post Traumatic Stress Disorder (PTSD) unit at Phoenix has already treated over 172 veterans. The treatment involves 90 days of hospitalization and appropriate long-term followup. The Phoenix PTSD Unit has a 16 bed capacity providing services to two groups of eight patients each at any given time. Because of the small size of the groups, which is considered therapeutically important, and the length of treatment, the program places a large demand on personnel resources, but it has proven very successful. At the present time, the program is working at its full capacity and has the potential for expansion if given additional resources.

The nursing shortage being felt across the country has also affected the Phoenix VAMC. The shortage is particularly acute during the winter months when the community hospitals intensify their recruiting to meet the influx of

winter visitors. Recently instituted special pay provisions may help us next winter in our recruiting efforts but, as the shortage affects the entire community, we may see further pay increases in the private sector that we may not be able to meet. A realistic expectation is that we will continue to experience serious nursing shortages in a seasonal fashion unless our salaries can keep apace with those in the community.

The increasing number of aging veterans is paralleled by an increasing demand for nursing home placements. Our 120 bed Nursing Home Care Unit maintains full occupancy and, in addition to our 120 beds, we have an assigned annual cumulative ceiling of 122 for the Community Nursing Home Care Program. The capacity of these two programs will be far exceeded by the demand in the forthcoming years and provisions for this will have to be made.

In conclusion, the continuing growth in demand, the aging of the veteran population, and the foreseeable recruitment difficulties will call for vigorous efforts to meet the needs of our veterans in the future.

STATEMENT OF F. C. LEPPERD, JR., M.D.

CHIEF OF STAFF, VAMC, PRESCOTT, ARIZONA

BEFORE THE

SENATE COMMITTEE ON VETERAN'S AFFAIRS

JULY 5, 1988

Thank you for inviting me to provide testimony concerning the following questions.

1. Overall issue of allocation of health-care resources to VA facilities in Arizona.

In my opinion, the allocation of health care resources in our Agency (including Arizona), has been affected by our national health care system which has become a giant industry. Additionally, it is very difficult to equate the deliverance of health care of our Agency to that of the private sector, i.e., veterans' care is complicated, multifaceted, and time consuming. The distances veterans must travel in the State of Arizona to obtain care, coupled with the lack of public transportation, is a severe deterrent to access. Available resources at Phoenix and Tucson VA Medical Centers are already overwhelmed by demand. Northwestern Arizona (Topock to Bullhead City) is experiencing an inordinate growth increase and I am in the process of exploring the possibility of an Outpatient Clinic in that area. Given the increased emphasis of quality assurance and utilization review, we frequently have great difficulty in producing documentation requested by society.

My personal observation also indicates that our Phoenix Regional Office is no longer timely in responding to veteran claims. I cannot speak to their resource needs.

2. Availability of surgical services for veterans residing in the Prescott area.

In view of distances between patients and VA facilities in Arizona, as well as the demands being placed on Phoenix and Tucson VA Medical Centers, I firmly support an in-house surgical program at Prescott. I believe access to care is compromised by the absence of this program at Prescott. Our experience since September 1986 suggests that there have been numerous problems involving this issue that have adversely affected our veterans. The great distances veterans must travel to receive care does create logistical problems. The Colorado River communities, with an estimated 12,000 veteran population, are over 250 miles from Phoenix. This frequently necessitates all day travel for our older veterans arriving for elective admission, or veterans arrive at Prescott for evaluation and must be lodged overnight until arrangements can be made with Phoenix or Tucson. In addition, Prescott PSA patients have

frequently complained about lag times in receiving outpatient appointments in clinics at both Tucson and Phoenix VAMCs.

In the interim period since inpatient surgical deactivation, Prescott has implemented numerous other programs. Included are:

a. Implement a 20-bed Intermediate Medicine Unit.
b. Provide increased ambulatory care capability.
c. Provided additional resources to the Domiciliary to accomplish their rehabilitative mission.

In preparation for possible continuation of in-house surgery the following has taken place:

a. Local community surgeons are in agreement to provide part time backup to VAMC surgical staff.

b. Recent inquiries have been received from two board certified anesthesiologists.

c. Community urologists have offered to provide full time coverage. A recently qualified candidate has made informal inquiries.

d. The surgical suite has been maintained and can be reactivated within approximately two weeks. Through reactivation of Surgical Service at Prescott VAMC, the facility will not only meet the future veteran demand and existing unmet demand, but also can offer some relief to Phoenix VAMC's already burdened workload by offering to provide surgical services for urology and orthopedics and related outpatient follow-up.

I recommend that Prescott be authorized to operate a 30 bed acute surgical unit to be re-evaluated at the end of three years.

3. Availability and quality of counseling and psychiatric services for Vietnam veterans through the Vet Centers in Arizona, the inpatient PTSD unit at the Phoenix VAMC and otherwise.

The Vet Center at Prescott should be authorized an additional FTE in order to employ a clinician. The VAMC at Prescott cannot adequately support all the clinical needs of the Vet Center.

In my opinion the PTSD program at Phoenix is excellent. I would defer to management at Phoenix to determine if resources match the demand.

4. Issues relating to the recruitment and retention of nurses at VA facilities in Arizona and the adequacy of current nursing staffing levels at those facilities.

Availability of nursing staff is a known national problem. The recruitment and retention of qualified nursing personnel in Northern Arizona is of even greater magnitude. This problem has been discussed with Chief Executive Officers in the private sector, i.e., Bullhead City, Kingman, Flagstaff and Cottonwood and all expressed great concern.

We are in the process of formulating a curriculum for training of nursing assistants with Yavapai Community College. This will be presented to appropriate State and VA officials when completed. Yavapai Community College has long had a two-year degree nursing program in which we have participated. We plan to utilize this program as a "career ladder" to provide more registered nurses for Northern Arizona. Obviously many factors must be considered such as housing, tuition, licensing, and retaining these newly trained nursing personnel in Northern Arizona.

5. Access of Arizona veterans to nursing home care, either at VA facilities or at VA expense.

Advanced age of the veterans in Arizona, along with no Medicaid, has created cause for concern. Arizona Health Care Cost Containment Service is in the process of revision in order to provide nursing home care without causing the spouses to be destitute. Prescott VA Medical Center is fortunate in that a new VA nursing home should be operational by early next summer.

CONGRESSIONAL TESTIMONY

SENATE COMMITTEE ON VETERAN'S AFFAIRS

PHOENIX, ARIZONA

JULY 5, 1988

Testimony by Mr. Dean M. McKee, Team Leader, Tucson Vet Center

Senator DeConcini and Members of the Committee:

My name is Dean M. McKee. As Team Leader of the Tucson Vet Center, I am pleased to have the opportunity to meet with you today and to discuss our work with Vietnam veterans in Tucson, Arizona. I am here to speak with you about the veterans we are working with, the progress we have made since the Vet Center opened in June of 1981, our observations on the changing needs of our veterans and our proposed efforts to meet those needs.

As you know, the Vet Center program was developed to address the continuing readjustment problems experienced by Vietnam veterans. These include: Post Traumatic Stress Disorder(PTSD), problems with employment, substance abuse, marriage and family and a variety of other issues. In many cases, these problems represent the psychological and social repercussions of military service during the Vietnam era. At the time the Vet Center program was initiated, many of these veterans had avoided or rejected services provided in traditional ways.

At the Tucson Vet Center, it has been our mission to address the readjustment counseling needs of veterans in southern Arizona, specifically veterans of the Vietnam era. Our service area includes Graham, Greenlee, Pinal, Pima, Cochise, Santa Cruz, Yuma and La Paz counties. We are also responsible for Hidalgo county in New Mexico.

In this service area, there are over 125,000 veterans. Of these, more than 40,000 served during the Vietnam era. Southern Arizona is a culturally diverse area with a variety of peoples including Anglo, Hispanic, Black and Native American. It includes both urban and sparsely populated rural areas. People from a variety of income groups are represented. The veteran population reflects the diversity of the general population with the result that there are many groups with unique and special needs. We have made considerable efforts to meet the needs of this veteran population.

Services are provided at our Tucson Center by a Team Leader, two Counselors and an Office Manager. Also, counseling is provided by contractors in rural areas.

Since opening the Center in 1981, we have achieved a number of successes, which we believe demonstrate both the availability and quality of our services. During the time since 1981, we have provided services for 3,497 new veteran clients and accomodated 16,416 client visits. As a result of our efforts, many of these clients have completed a course of counseling and are demonstrating continued individual success, as well as success within their families, on the job and in the community. Though we have had problems and shortcomings, we are proud of our record of service to our veteran community.

As I report on our progress and reflect on the problems that still must be addressed in our client population, I am reminded of my testimony given during the Arizona Oversight Committee of 1982. At that time, I described our mission as reaching Vietnam veterans who had remained unserved by traditional means and using short-term counseling techniques which relieved or reduced the readjustment problems they presented.

I am now pleased to report we have achieved additional successes. Many of the Vietnam veterans with acute problems have been reached and helped. Many of those who have received counseling in the past are returning for help with problems that have become more chronic and complex. As well as suffering from readjustment problems, Vietnam veterans now have concurrent psychiatric, substance abuse, and personality disorders which require long-term assistance.

As we have become more aware of these changes in our treatment population, we are working more closely with the Tucson Veterans Hospital. They have provided valuable support with psychiatric treatment, consultation and training. Although hospital staff shortages have taxed resources, we continue to successfully maintain our symbiotic relationship with the Tucson Veterans Administration Medical Center.

In addition, we are working closely with the Post Traumatic Stress Disorder Inpatient Program at the Phoenix Veterans Administration Medical Center. We have referred a number of veterans for treatment to this program. The Phoenix staff has worked effectively with our clients and we are involved in aftercare planning to maintain continuous care for our clients. In addition, we have referred some veterans to PTSD units in Menlo Park, California and North Chicago, Illinois.

In closing, I would like to thank you once again for the opportunity to give testimony before this Senate Committee on Veterans Affairs. We are proud of our successes, humbled by our shortcomings and eager to meet the challenges of the future. In concert with our local V.A. facility we are striving to meet the needs of our veterans and creatively adapt to future needs.

TESTIMONY OF CHESLEY B. GOODMAN JR.

VET CENTER TEAM LEADER, PHOENIX, ARIZONA

BEFORE THE

SENATE COMMITEE ON VETERANS' AFFAIRS

JULY 5, 1988

It is a pleasure to have been offered this opportunity to provide my testimony before this body. It is for this public forum and participation, for which, along with the rest of our freedoms, thousands of American lives have been given.

A short distance down the street from this location is Arizona's Viet Nam Memorial. On 10 slabs of marble are the names of the 638 young Arizonans who sacrificed their lives for this country in the Viet Nam war.

Since the date of the last death of an Arizonan in Viet Nam, his home state has nearly doubled, from a population of 1,775,399 in 1970, to a population of estimate of 3,475,500 in 1988. Indeed, if the young man were in some way able to return to Arizona today, he would scarcely recognize the urban areas of Arizona.

Metropolitan Phoenix for instance has swollen by over 55 per cent, from a population of 1,243,200 (1976) to a population of over 2 million, becoming the nation's tenth largest metropolitan population. Tens of thousands of his comrades in arms have migrated to Arizona, and in particiular to the Phoenix metropolitan area. The Viet Nam Era age group,and thus Viet Nam Era Veterans, constitute a disproportionate share of this new population. Phoenix metropolitan growth is estimated to be an additional 15.9 percent between 1986 and 1991, making it the fastest growing metropolitan area in the nation.

The Vet Center program was enacted by U.S. Congressional legislation in 1979, patterned after a highly successful pilot project pioneered by the Disabled American Veterans. The first Veterans Administration Vet Center opened in 1979, followed by many others, including Phoenix in 1980. The program was widely known within the Veterans Administration as "Operation Outreach". "Operation Outreach" was a highly innovative program, placed in the community, typically in "store fronts" to bring services closer to the Viet Nam Era Veteran, with a mission of going into the community to encourage use of the Vet Centers and Veterans Administration services. Vet Centers were staffed by peers-Viet Nam and Viet Nam Era Veterans-a typical team consisted of four persons. Vet Centers were opened nationwide, located in urban

areas and strategic rural locations. Many of the nations' larger cities received more than one Vet Center located in different parts of the city. The Vet Center program was wildly successful in its mission, and highly supported by the Veteran community. Subsequent expansions of the program have brought the current number of Vet Centers and satilites to 189, supplemented by a 5.5 million dollar contract program, in which Vet Centers contract with private agencies to bring similar services to harder to serve areas such as rural areas and outlying smaller towns.

The "rap group" constituted the core of Vet Center services, supplemented by "peer" counseling to Viet Nam Era Veterans and their families, employment counseliing, benefits counseling, and referral to VAMC's for traditional mental health and medical services. Additionally, the Vet Center aggressively outreached community mental health agencies, service organizations, clubs, and any one else in the community whose ear they could attract, providing education on identification of Viet Nam Era Veterans and readjustment issues, and raising consciousness to the plight of Viet Nam Era Veterans. The Vet Center program was highly successful in this task, and was at least partially responsible for the wide attention and respect the Viet Nam Era Veteran receives today in the newsprint, audio and visual electronic media and movies.

Almost simultaneous to the introduction of the Vet Center program, came the introduction of the psychicatric community's third edition of the Diagnostic and Statistical manual of Mental Disorders, a guide to the diagnosis of the various mental and emotional disorders, widely known in the mental health community as the "psychiatric bible". Contained in this volume was the first official scientific recognition of Post Traumatic Stress Disorder. While most of the research that led to the recognition of this emotional disorder was conducted on victims of civilian disasters, Post Traumatic Stress Disorder constituted a specific description of the clinical readjustment difficulties that many Viet Nam veterans were experiencing. I cannot over emphasize the importance of this development. Viet Nam veterans' readjustment problems could now be conceptualized as a clinical entitity rather than a subjective description of atypical behaiviors, or worse-misdiagnosis and inappropriate medical or psychiaric treatment. As with any change in society, acceptance of this change of diagnosis by the Mental Health Community was slow. The Vet Center was thrust into the position of being not only an advocate for the Viet Nam Veteran, but the primary treatment source for large numbers of Viet Nam veterans suffering from clinical or subclinical syndromes of Post Traumatic Stress Disorder. As the field medic and MASH hospital in the Viet Nam war became the

"leading edge" in emergency medical treatment, providing the technology that has subsequently saved countless lives; the Vet Center became the "leading edge" in diagnosis and treatment of Post Traumatic Stress Disorder. Sophisticated techniques in the diagnosis and treatment of Viet Nam Veterans and their families have continuoulsy been developed and improved upon with the Vet Center Program.

Concommitant with these developments, VAMC Mental Hygiene Clinics, psychiatric units, and, since 1985, VAMC inpatient treatment units are increasingly sharing this thrust of technological development. Almost daily, new developments in the treatment of Post Traumatic Stress Disorder are published in the professional Mental Health literature. With these increasing insights into the treatment of the disorder has come improved treatment. Veterans are, on the average, seen for significantly longer periods of time than when "Operation Outreach" made its pioneering efforts in 1979-1980. In addition to the continuing high number of veterans coming in for "first time" therapy, many veterans who were seen in earlier years are today returning for service.

The Phoenix Vet Center has experienced an increase in the complexity of cases presenting for treatment. We see more multiple tour combat veterans (the most consistent indicator or

predictor for PTSD is the amount of exposure to trauma). More multiple diagnoses (veterans with more than one psychiatric diagnosis-often including PTSD) are presenting for treatment. We see ever more family problems, as the children of Viet Nam Veterans enter their teenage years.

Program accountability assures quality of services by Vet Center staff. Accurate treatment records, regular staffing of all cases, and regular psychiatric and psychological consultation and supervision are all a part of current service delivery to Viet Nam Era veterans. Fiscal accountability is an essential part of Vet Center management.

In 1985, funding was provided for an inpatient treatment unit for Post Traumatic Stress Disorder at Carl Hayden Medical Center. The Phoenix Vet Center is proud to have participated in the planning of this highly successful and widely recognized sixteen bed treatment unit. We continue to participate actively with this treatment unit in the treatment of Post Traumatic Stress Disorder.

The state of Arizona, as indicated in highly publicized statistics and editorials in the Phoenix Rebublic and Gazette, ranks 52nd among all states and territories in spending for Mental Health. The Maricopa county suicide rate is second in the nation.

Maricopa county and the state of Arizona have one of the highest divorce rates in the nation. Metropolitan Phoenix has a very large homeless population. While I would not suggest that the Phoenix Vet Center should, or even possibly could fill these gaps in mental health care, the Vet Center is impacted, along with the other public Mental Health agencies in the community.

Since 1980, the Phoenix Vet Center has provided service to over 4500 Viet Nam Era veterans. We are currently providing consistantly high quality service to Viet Nam Veterans. We continue to be involved in the treatment of Viet Nam Veterans in the inpatient program for PTSD at Carl Hayden Medical Center, provide presentations and professional consultation to other Mental Health agencies, and maintain vigorous liaison with Carl Hayden Medical Center, and VA Regional Office in Phoenix. Vet Center services are supplemented by Arizona Department of Economic Security Disabled Veterans Outreach Program, the VA chronically mentally ill homeless program outreach worker, work studies, and volunteers. We are immersed in the Viet Nam Veteran Community. We are proud to continue to provide a high quality service in the face of explosive population growth, very low community Mental Health spending, few community resources, a large homeless population, increasing accountability, and increasingly complex cases.

STATEMENT OF RICHARD WAMBOLDT

VET CENTER TEAM LEADER, PRESCOTT, ARIZONA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

JULY 5, 1988

The specific issues which I would like to address is the availability and quality of counseling and psychiatric services for Vietnam veterans through the Vet Center in Prescott, Arizona, and the inpatient PTSD unit at the Phoenix VAMC.

The Availability of Counseling Services through the Vet Center

The Prescott Vet Center was opened in June, 1985. It is staffed by a three person team. Richard Wamboldt, ACSW, is the Team Leader. Judy Conley, BS, is the Office Manager. Bill Norton, LCSW, is the Readjustment Counseling Therapist. Auxilliary staff include a VA work-study student for 20 hours a week and a volunteer for about 30 hours a week.

The Vet Center maintains regular hours between 8:00 AM and 4:30 PM, Monday through Friday. There are group therapy sessions in the evening from 6:00 PM to 9:00 PM, two to three nights a week. Counselors are available after hours and weekends by special appointment and through the hospital switchboard for crisis situations. Counselors regularly visit veterans at the jail and hospital. The Vet Center has a toll-free telephone line so veterans can call at no charge. This service is good only in the state of Arizona.

The Prescott Vet Center has seen more than 850 new clients to date, with an average of 20-23 new clients monthly. In the year of 1987, 246 new clients were seen at the Vet Center. Recently, the number of counseling visits has approached and exceeded 200 per month. About 80% to 90% of the visits are by Vietnam theater veterans.

Another 30 or more counseling visits are seen by contract providers. Veterans living outside the immediate vicinity of the Prescott Vet Center have access to counseling through our fee basis readjustment counseling service contract program. The catchment area for the Prescott Vet Center includes five northern counties of Arizona. Those counties are Apache, Coconino, Mohave, Navajo, and Yavapai. Contract providers are located in Lake Havasu City, Riviera/Bullhead City, Kingman, Flagstaff, Winslow, Holbrook, Show Low, Springerville, St. Johns, Whiteriver, Cottonwood, and Sedona.

The northeastern area of Arizona is the Navajo Indian Reservation. It is the largest tribe and largest reservation in the United States. The reservation encompasses 25,516 square miles, or 16 million acres, and is about the size of the state of West Virginia. It has a population of about 162,000, of which perhaps 13,000 to 16,000 are veterans. About 3,000 to 4,000 of the veterans are of the Vietnan era. Over 1,000 fought in Vietnam.

I quote from a speech given on the reservation by Patrick J. Hannifin Vice Admiral, USN ret. "During the long war in Southeast Asia, 240 American Indians were killed and almost half of them were Navajo. In fact, the first American Indian killed in Vietnam was Navajo.... Twenty percent of all Navajo males (man, boy, and baby) are either veterans or are now serving in the Armed Forces. No other minority group in our country can match that!"

Health care on the Navajo Reservation is almost exclusively provided by the Public Health Service/Indian Health Service. This leaves little opportunity for private health care systems to compete, and therefore little chance of establishing the Readjustment Counseling Contract Program. The closest edge of the reservation is probably 140 miles from the Prescott Vet Center.

The best outreach effort is through collaboration between the Vet Center and PHS/IHS. Through information, referral, and training to PHS/IHS, we can expect some degree of increased awareness to readjustment counseling problems of the Navajo Vietnam veteran, and in turn, improved services through the PHS/IHS network on the reservation.

The VA American Indian Outreach Program on the Navajo Reservation was transferred from the Prescott VAMC to the Albuquerque VAMC more than a year ago. The Prescott Vet Center continues to maintain collaboration with this group for information and referral resources.

Quality of Counseling and Psychiatric Services for Vietnam Veterans through Vet Centers in Arizona

The quality of the Prescott Vet Center counseling is very good. Our counselors are experienced MSWs. Both are affiliated with the National Association of Social Workers, Academy of Certified Social Workers, the NASW Register of Clinical Social Workers, and NASW Diplomats in Clinical Social Work. The Readjustment Counseling Therapist is licensed by the state of California as a clinical social worker. The Team Leader is trained in psychotherapy and an Associate Fellow with the Institute for Rational-Emotive Therapy. Both counselors have non VA experience working in Psychiatric settings to include a state psychiatric hospital and a psychiatric residential care facility. Combined, the one and the one-third time counselors have more than nine years of experience counseling more than 1500 Vietnam veterans. The Team Leader is a member of the VAMC Mental Health Council.

There are usually five group therapy sessions conducted weekly by the Vet Center. A Tuesday night group is a resource group for combat veterans who have graduated from other Vet Center groups. This group runs for twelve sessions. A Wednesday night group, lasting twelve weeks, is for combat veterans who have never been in group before. A Thursday night aftercare group is for graduates of inpatient PTSD programs. This is an ongoing group. A Friday afternoon group is held at the VAMC alcohol rehabilitation program for the combat Vietnam veterans going through the program. There is also an intake group held for the Vietnam veterans in the domiciliary who are entering the Alcohol/Drug Treatment Program. A significant others group was held in the past and there are plans to re-establish this group pending enough new candidates for inclusion.

Once a week, the Vet Center receives external clinical consultation from the Director of the West Yavapai Guidance Clinic and from the clinic's psychiatrist.

The Prescott VAMC provides the Vet Center as much support as it can, considering its limited mental health resources. There are no PTSD beds at the Prescott VAMC and outpatient psychiatry is limited to service-connected disabled veterans. Other clinical and administrative support is very good.

Quality and Availability of the Inpatient PTSD Unit at the Phoenix VAMC

The Vet Center maintains a good working relationship with the Phoenix PTSD inpatient program. About two admission referrals a month are averaged. The waiting time for an admission screening is about five months. Close collaboration with Dr. Amato and the PTSD Unit staff can sometimes facilitate a shorter wait for our clients. The feedback we get from the veterans going through the program is generally favorable.

Conclusion

Overall, the quality and availability of Vet Center services is the very best that can be provided with a three person team. The catchment area is large and mostly rural. The staff members are highly dedicated and work long hours. The productivity level is at 200% and some very tough, difficult cases are handled at the Vet Center. The potential for staff burn-out is high.

HEARING

SENATE VETERANS' AFFAIRS COMMITTEE

July 5, 1988

Statement from:

Jose F. Amato, M.D.
Coordinator, PTSD Program

John L. Harrington, M.D.
Former Coordinator, PTSD Program

Page 1.

It is with pleasure that we have the opportunity to provide information to the Senate's Committee on Veterans' Affairs concerning the access of counseling and psychiatric services for the Vietnam Veteran.

Prior to 1980, Vietnam Veterans were primarily provided the same care as other eligible veterans at the Phoenix VA Medical Center. At that time a staff group consisting of a psychiatrist, psychologist, social worker and nurse attended a specialized training program for providing care to Vietnam Combat Veterans. This group then formed the core for initiating specialized treatment for Vietnam Combat Veterans. This was mostly done on an individual therapy basis but some group treatment both outpatient and inpatient, was established. Likewise, during this period liaison was initiated with the newly opened Phoenix Vet Center.

In October 1983 a multidisciplinary planning group, including Vet Center staff, was appointed by the Medical Center's Mental Health Council to identify specialized treatment and staff training needs required to provide optional care for Vietnam Veterans. In November 1983 this group recommended the establishment of a specialized inpatient treatment unit with an expanded outpatient program for Combat Post Traumatic Stress Disorder (PTSD). This was endorsed by the Mental Health Council. A proposal was submitted to VA Central Office in May 1984 consistant with the planning group's recommendations. This included a needs assessment which estimated that 5000 - 7000 Vietnam Veterans in Maricopa County alone, were in need of some type of psychiatric care/counseling.

The planning and implementation for a 16 bed inpatient specialized treatment unit was started in FY 85 with increasing input and participation from Vet Center staff. In January 1985 the first patients were admitted to the PTSD Program. The Program has assessed over 300 veterans and of these 70% have been accepted for treatment, and 127 have graduated. During the past year 85% of veterans admitted have graduated. The Program's current average length of stay is 87 days. It is very intensive treatment approach and addresses the psychological, physiological, social, interpersonal, etc., multifaceted needs of the Combat Veteran. Recently several Korean Combat veterans have also been admitted to the Program.

The responsibility for follow up care for graduates of the Program has been shared with the Staff of the Vet Center and the Mental Hygiene Clinic.

The Mental Hygiene Clinic has continuously provided screening for all veterans, outpatient treatment for eligible veterans and referral to the inpatient psychiatry service, as indicated. Outpatient treatment is provided for service connected Vietnam Veterans and a group of non-service connected Vietnam Veterans, particularly those in activ treatment at the Phoenix Vet Center. Currently there are over 200 non-service connected Vietnam veterans being followed in the Mental Hygiene Clinic with 50% of these being combat veterans. Psychiatric consultative supervision is also provided to the Phoenix Vet Center staff.

The Phoenix PTSD Program is one of 13 such VA designated Programs in the country. It is recognized for it's general and innovative approaches to treatment. The Program's staff has been involved in organization and participation in local, regional, and national seminars and programs for the diagnosis and treatment of Combat PTSD. The Program is a crucial part of the availability and continuity of care provided the Vietnam veterans in this state and maintains a close working relationship with the Vet Centers in Phoenix, Tucson, and Prescott. The Phoenix Vet Center staff has provided extremely valuable clinical assistance to the Program.

Currently, within budgetary restraints, it is our opinion that the specialized treatment needs of the Vietnam veteran in the Phoenix area are being appropriately addressed. The increasing numbers of Veterans who are coming to this area has placed a strain on available resources. The problem of availability of care for Vietnam veterans,as well as all veterans, will be an ongoing challenge.

TESTIMONY

Of The

ARIZONA NURSES' ASSOCIATION

Concerning

REGISTERED NURSE RECRUITMENT AND RETENTION

AT VA FACILITIES

Before the

SENATE VETERANS' AFFAIRS COMMITTEE

HEARING IN PHOENIX, AZ

July 5, 1988

PRESENTED BY

Catherine Budd Hoffman, R.N., M.N.

Denise Hallfors, R.N., M.S.N.

Mr. Chairman, I am Catherine Budd Hoffman, R.N., M.N., a registered nurse from Phoenix, a member and today a spokesperson for Arizona Nurses' Association (AzNA). With me is Denise Hallfors, Executive Director of Arizona Nurses' Association. In preparation for this hearing I have met with nursing colleagues at Phoenix VA Medical Center in order to validate the following remarks concerning recruitment and retention of VA nurses in this community. I thank you for the opportunity to appear today and present written testimony.

First of all, Arizona Nurses' Association would like to thank the committee for the passage of several provisions of S. 9 which enhanced the ability of the VA to recruit and retain nurses already. After several years of health care staff reduction, brought on in part by current federal payment policies, a trend is emerging in the health care industry: a shortage of registered nurses. Phoenix is no different than other parts of the country. Today, Phoenix valley hospitals report numerous nursing vacancies. The vacancy rate is difficult to determine, however one 1987 estimate has been cited as nine percent. This Arizona Hospital Association study comments on the difficulties in ascertaining reliable numbers for RN vacancy rate and chose to also report another measure of the problem, the use of temporary RN pool in the survey week. During one week, the responding hospitals contracted 20.3 shifts of outside RN staff.

Contrasting this figure with the national average of 10.8 shifts per week, Arizona may have a larger problem with RN vacancy than the nine percent average may imply. (Arizona Hospital Association, (AzHA), 1988)

My VA colleagues remind me that conditions that have contributed to the shortage are no different between a community, non-profit hospital and the federal hospitals. In times past perhaps there was delay before economic changes in community hospitals and when those changes affected the VA system. That lag time is non-existent now. VA medical centers need to be as responsive and in this case as competitive as their community counterparts in order to recruit and retain nursing staff.

The nursing shortage, no matter which facility, is critical because people in need of nursing care are seriously ill. Current payment policies by the federal government have created situations in which patients are generally admitted only for the very acute portion of their illness. Therefore the average patient is more acutely ill than in past years, and requires a more intensive level of nursing care. Eighty-nine percent of Arizona hospitals report increasing acuity within their institutions. (AzHA, 1988) For example, the average length of stay for a patient with a myocardial infarction (heart attack) is approximately six days and a patient undergoing major coronary bypass surgery can anticipate a stay less than a week. Two to

three of those days will be spent in an intensive care unit, with only four days to regain strength and learn about self-care for discharge. This has placed an additional demand on nursing staff, who are now required to have far more sophisticated skills to perform physical assessments, monitor and utilize high technology equipment, teach patients and their families and prepare discharge plans.

In response to Medicare's prospective pricing system hospitals have cut nursing budgets, laid off nurses, and halted recruitment and retention efforts. We believe that as a result of these developments, the average workload of registered nurses has increased markedly and has been largely responsible for the acute emergence of the current nursing shortage.

In order to alleviate the immediate shortage, AzNA as a member of the American Nurses' Association endorses the following short range strategies for dealing with the nursing shortage. Immediately increase the time that registered nurses spend with patients by reallocating resources and developing staffing to:

* change the salary and benefit structure to retain experienced nurses;
* help nurses who work part-time to return to full-time employment;

* employ nursing assistants and licensed practical nurses to assist registered nurses in the support tasks essential to patient care.

Regarding the ability to change salary and benefit packages, my VA nursing colleagues emphasized that a shorter turnaround time is imperative on these matters from the Washington offices. As long as four months' time can transpire between suggested changes at the local level and a response from higher authority. This does not place VA hospitals in a competitive posture for nurses. My own experience with such changes in the Phoenix valley is that salary adjustments and perks can be negotiated and marketed as frequently as every other month if need be to compete.

It was interesting for me to learn that the majority of nurses in the Phoenix VA hospital are actually full-time employees. This speaks well for the system. Incentives to work full-time not only help to relieve the shortage but improve continuity of patient care, enhancing the quality of a patient's hospitalization. Part-time employment is on the increase elsewhere and therefore the VA system needs to prepare for that kind of change by maintaining and enhancing the incentives to work full-time.

One of the disincentives to working full-time currently in the VA system is that as a full-time employee a nurse could not work in

another hospital to pick up extra hours. This is surely not the case in any other Phoenix valley institutions of which I am aware. Some nurses, particularly single parents, view this as restriction of practice and livelihood.

Another short range strategy to quickly expand the overall pool of registered nurses who work in hospitals and long term care facilities is the support of educational mobility for LPNs, Nursing assistants, nurses prepared at the Associate degree level. Tuition reimbursement has been adequate for nurses in the Phoenix VA system, however it is anticipated with progress and change in this state's Nursing Practice Act that many more nurses will seek further education. The VA will need to compete with other hospitals in their benefit package. Nurses have already learned the value of tuition reimbursement to their futures and look for this perk right after the discussion of health care insurance plans. Note that tuition reimbursement keeps nurses practicing in hospitals while they return to school, rather than taking leaves of absence to do so.

Nurses in Arizona would like to thank you for establishing a tuition reimbursement program for nurses pursuing courses leading to a bachelor or an advanced degree in nursing. The Arizona Hospital Association's survey of Nursing personnel reported Directors of Nursing who desire 59% of their nurses to hold

baccalaureate degrees. Currently the average number of BSN's is twenty-seven percent. (AzHA, 1988)

A shortage of registered nurses also often leads to ineffecient use of hospital facilities. In some hospitals, for example:

* Patients are refused admission to intensive care units;
* Patients are admitted to ICUs because of a shortage of medical/surgical nurses to provide care needed in those areas;
* Patient transfers may be delayed;
* Patients may miss, or be incompletely prepared for diagnostic tests; or
* Hospitals may be forced to close beds to admissions.

I suspect you have heard or read of VA hospitals where these situations have arisen. Phoenix VA closed an entire surgical ward this past February. The cause -- inadequate nurse staffing.

Another important strategy for easing the nursing shortage involves the appropriate use of nursing support personnel. The VA system has various levels of health care personnel that assist nursing, relieving nurses of tasks that do not require nursing skill and knowledge. The budgetary cuts to nursing have also cut away at these support systems. A graphic example given to me was that there simply are not enough housekeepers to clean and prepare a hospital room for the next occupant. Therefore

housekeeping cleans the bed, but nursing must make the bed with clean sheets. Time spent making a bed is time spent away from patients, time not available to answer call lights, time not available to assess a patient's pain level, time not available to coordinate discharge plans.

Not having the time to give the nursing care that your patients need is clearly a primary cause of job dissatisfaction for nurses. Nursing care must be constantly prioritized to guarantee a technically safe practice. Data reported quarterly within the VA system through the AMIS Reports document chronic understaffing. Staffing is determined through a patient classification system which evaluates the hours of nursing care required for a group of patients. The quarterly reports summarize the required hours of care in comparison to the actual hours of care delivered.

Finally, Congressional strategies related to recruitment and retention of registered nurses should build on research already done in this country on practice models and patient care alternatives. The American Nurses' Association believes the VA's Nursing Service has the professional knowledge and experience to determine what is appropriate for nursing practice in the VA. ANA urges the Administrator for VA services to provide adequate levels of funding and administrative support to allow nursing to implement its programs which are supported by existing nursing

research. Try not to reinvent the wheel through legislated change, rather support financially the system to solve its problems.

In closing, I will paraphrase what was said to me by nurses as I left the VA hospital this week, "Tell them we are dedicated to this job of caring and that we work hard at it." Clearly there was sincerity and pride in their voices.

1987 Arizona Hospital Nursing Personnel Survey. Arizona Hospital Association, February, 1988.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

RICHARD D. HOOVER, PAST NATIONAL PRESIDENT

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

VA HEALTH CARE IN ARIZONA

FIELD HEARING, PHOENIX ARIZONA

JULY 5, 1988

Mr. Chairman and Members of the Committee, it is an honor for me to present the views of Paralyzed Veterans of America (PVA) on the important issue of access of Arizona veterans to Veterans Administration health care. Mr. Chairman, as a constituent and resident of Arizona, as well as a consumer of VA health care, I hope to be able to provide this Committee with some insight into the problems being faced by Arizona veterans with regard to VA health care delivery.

I. Overview of VA Health Care in Arizona

As you know, PVA, in 1987, published the results of its health care study entitled, "Veterans' Health Care: Actions and Interactions." PVA contracted with the American Health Planning Association (AHPA) to study the impact of

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both proposed and enacted policy changes at the national level which affect veterans' health care delivery.

The study focused on four medical districts in the VA system to provide a cross-section for analysis. Medical District 24 (M.D. 24) was included in this study in detail. I will refer to the findings of Actions and Interactions throughout the text of my testimony.

M.D. 24 contains one of the largest geographic areas incorporated into a single VA district. It includes the states of New Mexico and Arizona, as well as 88 counties in Texas. A sunbelt region, this area is experiencing rapid migration from other regions with a population growth projected to exceed 30% in the next decade. Arizona is the fastest growing of the states in M.D. 24. Arizona is one of two states in which the veteran population, as a whole, will steadily increase through the year 2000. Between 1970 and 1980, Arizona gained 126,000 veterans and the numbers continue to grow. In addition, Arizona is attracting increasing numbers of retirees, contributing to an aging of the general population at a rate considerably above the national average and accentuating the aging trend in its veteran population. In 1980, 11.1 percent of M.D. 24's veterans were 65 or older; in 1990, 26.8 percent of the district's veterans will be 65 and older.

The number of veterans in M.D. 24 with incomes below $15,000 per year is estimated to be at or near 310,000. These figures are important in light of Public Law 99-272, the "Means Test," which establishes these veterans as eligible for Category A priority access to VA medical care. Income levels in all of M.D. 24 are, on the average, lower than the rest of the country. In

addition, 85 percent of the counties in the district are designated as medically under-served areas (MUAs) by the Department of Health and Human Services.

The veteran population in Arizona was 371,000 in 1980 (total veteran population in M.D. 24 = 800,000 in 1980). This number is expected to reach 393,000 by 1990.

The VA operates three medical centers in Arizona; the VAMC in Phoenix, a 590 bed tertiary medical center with a 120-bed nursing home unit and outpatient services; the VAMC in Tucson, a 325 bed tertiary care facility and a 41 bed nursing home unit (plans for Tucson include increasing the nursing home unit to 120 beds and further expansion of geriatric services) and the VAMC in Prescott which consists of a 217 bed hospital and a 214 bed domiciliary unit. Prescott provides primary and secondary medical and surgical care and refers patients requiring tertiary care or highly specialized treatment to other VAMCs in the district, primarily, Phoenix. The total numbers of VA beds in Arizona are as follows:

Acute and intermediate	=	1,132
Nursing Home	=	161
Domiciliary	=	214
TOTAL		1,507

According to the 1984 MEDIPP Plan, the three VAMC's in Arizona treated 22,183 eligible veterans in 1981-1983.

Veterans with service-connected disabilities account for approximately 35 percent of all VAMC discharges in the district. Data on VAMC utilization

according to income are not available. However, income characteristics of the general population of district 24 would indicate that a large number of VA users are in low income groups.

The fact that a large number of VA users are low income would deem them unlikely to be able to receive care in the various private sector hospitals in Arizona. "Actions and Interactions" demonstrated that probably only 20 percent of users of VA inpatient services have "good" health insurance. The Arizona Health Care Cost Containment System (AHCCCS) currently requires an individual's income not to exceed $2,500 per year, and total assets may not exceed $30,000. This income threshold is one-sixth of the Category A income threshold for VA care under Public Law 99-272. If the VA fails to provide for the increased demand for medical care which will take place in the 1990's, the result will be the displacement of veterans from the VA and will represent a cost shift to the health care budgets of other federal programs (Medicare, Medicaid), states, local governments and the individual. If displaced veterans, unable to receive care from the VA, were to enter into AHCCCS after spending down to the $2,500 threshold, the annual cost shift per displaced veteran under 65 would be $755 to the state and a similar amount to the county of residence. Certainly, private sector beds are no alternative, especially, in light of the fact that AHCCCS is not a provider of any type of long-term care.

II. Nursing Home Care in Arizona

Aging of the veteran population in M.D. 24 will increase the need for chronic care beds to a projected census of 1,486 in 1995, a substantial increase over 1983's 686 beds. The veterans for whom the VA accepts responsibility may be

cared for in VA-owned beds, community beds under contract, or in state home beds.

The district plans to meet 15 percent of the total need for nursing home beds among veterans by 1995. Specifically, the 1984 MEDIPP plan projects a VA nursing home census of 598, a community bed census of 793, and a state-owned bed census of 95 in 1995, a total census of 1,486. The 1984 MEDIPP plan indicated that 630 VA nursing home beds will be needed in 1990 and suggested a total of 300 of these beds be in Arizona (120 in Phoenix, 60 in Prescott and 120 in Tucson).

The aging trend, coupled with in-migration by elderly people, will have a substantial effect on the ability of the VA to meet the long-term care needs of veterans in Arizona. An important aspect of this rapid increase in the number of elderly veterans in planning is the expected six-fold increase in veterans 75 and older between 1980 and the year 2000. This age group uses more health services than younger groups.

In 1984, Arizona had a total of 10,411 existing nonfederal nursing home beds. However, taking into account the substantial increase in the elderly population projected in the 1990's, the existing VA policy which calls for 40 percent utilization of community beds could result in displacing non-VA patients from a scarce supply of beds in the absence of construction of sufficient beds.

In conclusion, given the projected increase in need for community nursing home beds to meet the needs of community residents, the district's proposed

strategy concerning the number of veterans to be supported in community beds by 1995 is unrealistic, unless there is considerable construction. Otherwise, the VA will be competing for available beds with other federal payment programs, such as Medicare and Medicaid.

PVA's study, "Actions and Interaction," states that such competition would have the effect of driving up costs to all payers, as well as the potential for displacing nonveterans requiring nursing home care from available capacity.

Perhaps the most enlightening finding of "Actions and Interactions" is the acknowledgement that all future planning for the medical care needs of Arizona's residents, both veteran and nonveteran, is that such planning cannot be done in isolation. There is an American health care delivery system, no matter how loosely organized, and the VA is a part of that system. The VA health care system does not stand apart, thus lending itself to totally independent study. The VA cannot be considered as separate from the rest of the health care structure.

Proposed cutbacks in VA health care resources come at a critical time for veterans. The veteran population is aging rapidly, presenting different health care needs. More, not fewer, resources will be required to meet the nation's commitment to these older veterans. The non-VA health system is changing in ways which may make it more difficult for poor veterans and older veterans to obtain needed health care from non-VA sources.

The results of "Actions and Interactions" suggest that adequate capacity is available in the private sector to absorb some of Arizona's veteran patients. However, these hospitals and nursing homes do not seek to provide free care in a competitive environment, and most current and potential users of VA medical care in Arizona lack the financial means to access such service.

Mr. Chairman, in 1983 the Administrator of Veterans Affairs directed that plans for a Veterans Administration Prototype Nursing Home be established. After this had been accomplished, other government agencies and veterans' service organizations expressed concern that the design did not comply with minimum Federal accessibility standards. In 1985, the VA Inspector General, upon examination of the design agreed with that position. The VA had already pressed forward with the utilization of the prototype design at three locations.

The General Services Administration permitted the VA to proceed with construction if a study was accomplished to show that the prototype design was acceptable to severely handicapped and elderly disabled individuals as the Veterans Administration maintained. Such a study as originally agreed upon has yet to be accomplished and the VA is rapidly turning an unacceptable prototype into the standard of the Agency.

In Arizona, we have one nursing home under construction in Tucson, and are on the way to the beginning of State Veterans Nursing Home under the joint Federal/State program. That joint program is being accomplished under the direction of the Arizona State Veterans Service Commission. It would be disastrous and quite expensive to have to retrofit completed facilities. I

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urge you, Mr. Chairman, to urge the Veterans Administration to act quickly on correcting what is clearly an unacceptable design.

III. Retention and Recruitment of Nurses

As the demand for VA health care rises, so too will the need to recruit and retain qualified nurses to administer that care. The critical shortage of registered professional nurses which exists today is a national problem. PVA has testified before Congress on numerous occasions regarding this disconcerting and complex problem. The Committees on Veterans' Affairs, both House and Senate, have demonstrated a strong commitment towards resolution of the nursing and allied-health professional shortage being experienced by the VA. Provisions contained in Public Law 100-322, recently enacted, will address critical retention and recruitment issues such as Bonus pay, Saturday premium pay, scholarship and tuition reimbursement programs. The House and Senate Committees both also have pending legislation which will further address solutions to ease the shortage of VA health care professionals. The Members of the Committees are to be commended including you, Senator DeConcini, for your steadfast determination in resolving this serious threat to the quality of VA health care.

The statistics say that the proportion of vacant positions for registered nurses in hospitals doubled between September 1985, and December 1986, reaching the levels of the last national nursing shortage in 1979.

The VA's report, "1986 Survey of Health Occupational Staff," identified "seriously difficult" staffing problems with regard to Registered Nurses at

both VAMC's, Phoenix and Prescott. VAMC Tucson's staffing conditions for Registered Nurses were described as "moderately difficult."

At the February 3, 1987, hearing of the House Committee on Veterans' Affairs, the Administrator was asked a question regarding the shortage of VA Registered Nurses to which he replied, "Based on across-the-board data as recent as the last 60-90 days, we found that there is, overall, no nursing shortage."

It is this lack of commitment or cognizance on the part of an insensitive administration, compounded by public misinformation, general malaise, and "bottom-line" budget managers, who tend to make decisions in a vacuum, who cause the professional's cloak of dedication to begin to fray. The impact of this issue needs to be magnified, not minimized, if a a reasonable solution is to be realized. Even the glaring results of the Health Occupational survey were couched in language obviously meant to minimize the impact of the data. For example, the study states, "The staffing index shows that 45.5 percent of the facilities are experiencing favorable staffing conditions for registered nurses." What the study is really saying, although it never says it directly, is that 54.5 percent of all VA medical facilities are experiencing staffing conditions other than favorable. PVA believes that any staffing condition less than favorable, at the very least, results in a decrease in the quality of care received by veterans, if not resulting in conditions which are down right hazardous.

In reviewing the unsettling results found in the 1986 "Survey of Health Occupational Staff," who can blame them for looking elsewhere. And, who can

blame potential VA applicants for choosing another place to work with VA morale at an all time low.

To PVA though, the issue is even more complex than mere retention and recruitment of licensed or certified health-care professionals. We contend that to surrender the care of this nation's veterans to anyone less than the finest caliber of personnel is a grave injustice. The issue then becomes further compounded as the VA enters the on-going, nationwide competition for the most discerning, quality-conscious professional applicants from a limited pool of resources. Stand-alone, quick-fix solutions simply will not work. They rarely do. The problem did not surface over night, and it won't be solved in one day either. The health care field tends to attract humanitarian and altruistic professionals. Typically, these professionals tend to believe that their job goals should be more rewarding than just their salary. PVA has enough familiarity with the health care environment and has enough health professionals on staff to know that the average professional will put up with a lot of difficult conditions before calling it quits. The nurses, pharmacists, and therapists leaving the VA have experienced working short-staffed, with little or no support, excessive overtime and endured many weekend and off-shift tours of duty.

Some of the difficulties of these professions can be resolved with higher salaries; some with greater educational opportunities; and some with more career mobility. Each has its own unique needs, but one requirement all have in common is the need to know that the Administration is committed to them and the maintenance of quality VA Health Care. Authorizing salaries which are lower than hospital maintenance workers is not commitment, asking an

employee to work so short-staffed that he or she is actually putting his/her professional license in jeopardy is not commitment, and, when an institution fails to reimburse or otherwise discourages its employees from continuing their professional education, it is the same as saying (we) do not have a vested interest in your future, (we) are indifferent toward your professional improvement; (we) are satisfied with the status-quo. PVA believes that when a health-care professional stops pursuing new knowledge, his or her professional growth stagnates. When any of these conditions exist, the quality of care received by the veteran is reduced, and perhaps no one knows more acutely than our members, who have suffered a catastrophic injury. Quality of care can mean the difference between life and death.

PVA would like to reiterate the gravity of this problem and the need for Arizona to collectively decide approaches which will benefit the VA, while at the same time, avoiding negative competition with the private sector for qualified nurses. This is a problem of national significance, a problem to Arizona and a problem to each and every one of us. The solutions, if they are to be workable and lasting, must come from us all.

SENATE COMMITTEE ON VETERANS AFFAIRS
OVERSIGHT HEARINGS
PHOENIX, ARIZONA
JULY 5,1988

TESTIMONY OF EARL W. BOWERS
PAST STATE COMMANDER
DISABLED AMERICAN VETERANS

MR. CHAIRMAN, I WISH TO EXPRESS MY APPRECIATION TO SENATOR CRANSTON AND ALL OF THE MEMBERS OF THE SENATE COMMITTEE ON VETERANS AFFAIRS FOR ALLOWING ME THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY. ON BEHALF OF ALL ARIZONA DISABLED VETERANS, I THANK YOU.

THE HEALTH CARE CONCERNS OF DISABLED VETERANS IN ARIZONA ARE VERY REAL, THEY SHOULD AND MUST BE ADDRESSED. DUE TO THE INFLUX OF VETERANS MOVING TO ARIZONA FOR HEALTH REASONS AND THE WINTER VISITORS WHO SPEND SIX TO NINE MONTHS OF EACH YEAR IN ARIZONA, THE VETERANS ADMINISTRATION HEALTH CARE SYSTEMS IN PHOENIX, TUCSON AND PRESCOTT HAVE BECOME OVERBURDENED, INADEQUATE AND OBSOLETE. AS YOU MAY RECALL, I APPEARED BEFORE THIS

COMMITTEE IN FEBRUARY OF 1982 ON BEHALF OF THE DISABLED AMERICAN VETERANS. OBVIOUSLY, THE TESTIMONY GIVEN BY ME, AND OTHERS FOR THAT MATTER, HAD VERY LITTLE OR NO IMPACT WHATSOEVER. NOTHING HAS CHANGED, IN FACT, VETERANS HEALTH CARE IS PROGRESSIVELY VANISHING FROM THE REACH OF VETERANS. VETERANS HEALTH CARE DIMINISHES WITH EACH NEW APPROPRIATION.

MR. CHAIRMAN, I AM NOT GOING TO BORE THIS COMMITTEE WITH SO CALLED STATISTICS. FOR STATISTICS ARE NOTHING MORE THAN EYEWASH. THEY CAN BE BENT, TWISTED AND SLANTED IN ANY DIRECTION TO SATISFY ONE'S POINT OF VIEW. THE FACTS AND REALITY IN THIS URGENT PLEA IS FOR PROPER AND ADEQUATE FUNDING TO MAINTAIN AN EFFECTIVE AND COMPETENT HEALTH CARE DELIVERY SYSTEM FOR AMERICA'S FREEDOM FIGHTERS, THE DISABLED VETERANS. VETERANS SHOULD NOT HAVE TO PLEAD AND BEG FOR THE BENEFITS THEY EARNED ON THE BATTLEFIELD. WHEN ONE HUNDRED PERCENT SERVICE CONNECTED VETERANS MUST SEEK OUTSIDE MEDICAL SERVICES IN THE PRIVATE SECTOR AT THEIR OWN EXPENSE, IT IS TIME TO SOUND THE ALARM AND LET THE PRESIDENT AND THE CONGRESS KNOW THAT THE UNITED STATES GOVERNMENT IS

RENEGING ON THEIR COMMITMENT TO DISABLED VETERANS.

MILLIONS OF YOUNG AMERICANS UPHELD THEIR COMMITMENT TO THE UNITED STATES GOVERNMENT. THAT COMMITMENT WAS TO DEFEND THE FREEDOM OF THE UNITED STATES AT ALL COSTS. A GREAT MANY YOUNG AMERICANS ANSWERED THE CALL TO DUTY AND PAID A VERY HIGH PRICE FOR THAT FREEDOM. THEY GAVE THEIR LIVES, SOME NEVER HAVING HAD THE OPPORTUNITY TO VOTE IN AN ELECTION. THOSE WHO WERE FORTUNATE ENOUGH TO SURVIVE, RETURNED WITH THEIR MINDS AND BODIES ABUSED AND MAIMED, WHILE OTHERS WERE DISFIGURED AND DISMEMBERED.

I AM INCLINED TO BELIEVE THE PRESENT ADMINISTRATION HAS NO COMPASSION NOR SENSITIVITY TOWARD THOSE OF WHOM THEY SPEAK SO ELOQUENTLY WHEN THE OCCASION SERVES THEIR PURPOSE. FLOWERY SPEECHES ON THE BEACHES OF NORMANDY OR KIND WORDS AT THE TOMB OF THE UNKNOWN SOLDIER WILL NOT HEAL THE WAR RAVAGED MINDS AND BODIES OF VETERANS, NOR WILL ACCOLADES AND PRAISE ON MEMORIAL DAY AND VETERANS DAY, FOR THOSE WHO DEFENDED FREEDOM WITH THEIR LIVES. MR. PRESIDENT AND MEMBERS OF CONGRESS, DISABLED VETERANS NEED ADEQUATE AND PROPER APPROPRIATIONS TO FUND THE HEALTH CARE

NEEDS OF VETERANS. KIND WORDS AND APPLAUSE WILL NOT SUFFICE. ALL WE ARE ASKING THE GOVERNMENT TO DO IS UPHOLD THEIR END OF THE COMMITMENT, BY PROVIDING SUFFICIENT FUNDING TO SERVE THE NEEDS OF VETERANS WITH WAR TORN BODIES, AND DISEASES ACQUIRED WHILE SERVING THE UNITED STATES IN FOREIGN COUNTRIES. IS THAT TOO MUCH TO ASK OF A GRATEFUL NATION IN EXCHANGE FOR SERVICES RENDERED?

AS A PAST STATE COMMANDER OF THE DISABLED AMERICAN VETERANS, A MEMBER OF THE MILITARY ORDER OF THE PURPLE HEART, A MEMBER OF THE 87TH INFANTRY DIVISION ASSOCIATION, THE AIR FORCE SERGEANTS ASSOCIATION AND A MEMBER OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, I HAVE HAD THE OPPORTUNITY TO TRAVEL THROUGHOUT ARIZONA. I HAVE TALKED TO VETERANS, FAMILIES OF VETERANS, WIDOWS OF VETERANS AND FROM TIME TO TIME I HAVE TALKED TO SONS AND DAUGHTERS OF VETERANS. THE NUMBER ONE TOPIC OF DISCUSSION IS HEALTH CARE FOR VETERANS. THE QUESTION MOST ASKED IS, WHY IS THE FEDERAL GOVERNMENT RENEGING ON HEALTH CARE FOR VETERANS?

THE COMPLAINTS I AM HEARING COME IN ALL CATEGORIES RANGING FROM: SIX TO EIGHT HOURS WAITING TIME TO SEE DOCTORS, DENIAL OF

MEDICAL SERVICES AT MEDICAL CENTERS, VETERANS TRAVELING LONG DISTANCES TO THE MEDICAL CENTER AND THEN BEING TOLD TO COME BACK THE FOLLOWING DAY BECAUSE THE DOCTOR IS OVERBOOKED, WAITING FOR MONTHS TO OBTAIN AN APPOINTMENT, DENIAL OF CERTAIN MEDICATIONS SIMPLY BECAUSE THEY CAN BE PURCHASED OVER THE COUNTER IN A DRUG STORE, TOO LITTLE TIME SPENT BY RATING DOCTORS EVALUATING VETERANS HEALTH PROBLEMS, VETERANS OVER MEDICATING THEMSELVES DUE TO INADEQUATE SUPERVISION BY DOCTORS WRITING PRESCRIPTIONS, DRUG PROFILES NOT BEING SCREENED WHEN NEW PRESCRIPTIONS ARE WRITTEN, ADJUDICATION OF RATINGS BASED ON A TEN MINUTE OR LESS RATING EXAM BY VA DOCTORS, POSSIBLE VIOLATIONS OF THE FEDERAL PRIVACY ACT CONCERNING VETERANS WITH PSYCHOLOGICAL DISORDERS AND THE CHIEF COMPLAINT IN REGARD TO THE VA REGIONAL OFFICE IS THE LACK OF RESPONSE OR ACKNOWLEDGEMENT TO LETTERS OF INQUIRY FROM VETERANS OR THEIR FAMILIES.

I AM FAMILIAR WITH ONE CASE WHERE THE VETERANS WIFE DROVE HIM TO THE TUCSON VA, WHICH IS 280 MILES ROUND TRIP, FOR AN EYE APPOINTMENT. WHEN THE VETERAN ARRIVED HE WAS TOLD THE PROCEDURE

COULD NOT BE ACCOMPLISHED DUE TO THE RETIREMENT OF THE TECHNICIAN WHO OPERATED THE EQUIPMENT. IT WAS STATED THAT THE PROCEDURE MUST BE ACCOMPLISHED ON A FEE BASIS AND PERMISSION MUST BE REQUESTED. IN THE INTERIM, THE VETERAN WENT TO A PRIVATE SECTOR EYE CLINIC AND HAD SURGERY PERFORMED AND PURCHASED NEW GLASSES AT HIS OWN EXPENSE. I KNOW OF THIS INCIDENT BECAUSE IT COST ME $500. MR. CHAIRMAN, I COULD CITE VOLUMES OF COMPLAINTS THAT VETERANS OR THEIR FAMILIES HAVE SHARED WITH ME. HOWEVER, THESE INDIVIDUALS REFUSED TO PUT THEIR COMPLAINTS IN WRITING AND SIGN THEM DUE TO FEAR OF REPRISAL. OVER THE PAST SEVERAL YEARS I HAVE ADVISED VETERANS AND THEIR FAMILIES TO SUBMIT THEIR COMPLAINTS TO THE OFFICE OF SENATOR DECONCINI IF THE VETERANS SERVICE ORGANIZATIONS CAN NOT ASSIST THEM. I AM CERTAIN THE OFFICE OF SENATOR DECONCINI HAS RECEIVED NUMEROUS LETTERS CONCERNING VETERANS HEALTH CARE.

I WILL NOT TAKE UP ANY MORE TIME FOR I KNOW THERE ARE OTHERS WHO WISH TO CONTRIBUTE TO THESE HEARINGS. I HAVE ATTACHED LETTERS OF COMPLAINT I PERSONALLY HAVE ENCOUNTERED IN

VETERANS HEALTH CARE, I AM CONFIDENT OTHERS WILL ALSO SUBMIT LETTERS OF COMPLAINT.

MR. CHAIRMAN, I WISH TO ADVISE YOU AND THIS COMMITTEE THAT THIS TESTIMONY IS NOT BEING GIVEN ON BEHALF OF THE DISABLED AMERICAN VETERANS ORGANIZATION, IT IS BEING GIVEN AS AN ADVOCATE FOR DISABLED VETERANS RESIDING IN ARIZONA WHO ARE FEARFUL OF LOSING BENEFITS SHOULD THEY COMPLAIN ABOUT INEQUITIES IN THE VETERANS ADMINISTRATION HEALTH CARE SYSTEM. IT BEHOOVES ALL VETERANS TO SPEAK OUT FREELY FOR THE BENEFIT THEY HAVE EARNED ON THE BATTLEFIELD WHILE PRESERVING THE FREEDOM OF THE UNITED STATES.

IN CONCLUSION MR. CHAIRMAN, I WISH TO THANK YOU AND THE MEMBERS OF THE VETERANS AFFAIRS COMMITTEE FOR ALLOWING ME TO APPEAR HERE TODAY, TO SPEAK OPENLY, AND FREELY ON BEHALF OF ARIZONA DISABLED VETERANS. THANK YOU.

TESTIMONY SUBMITTED BY:
EARL W. BOWERS
PAST DEPARTMENT COMMANDER
DISABLED AMERICAN VETERANS
AND
MEMBER OF
THE MILITARY ORDER OF THE PURPLE HEART

TESTIMONY OF RAYMOND A. PELKEY
AMERICAN EX-PRISONERS OF WAR, DEPARTMENT OF AZ
CONCERNING SURGERY AT THE PRESCOTT VA MEDICAL CENTER

IN JULY OF 1986 A RUMOR STARTED CIRCULATING IN THE PRESCOTT ARIZONA VA MEDICAL CENTER THAT A MISSION CHANGE WAS COMING WHICH WOULD ELIMINATE INPATIENT SURGERY. THIS RUMOR RESULTED IN TWO OF THE THREE SURGEONS ON STAFF TO ACCEPT EMPLOYMENT ELSEWHERE. ALSO, DUE TO THE RUMOR, NEW SURGEONS COULD NOT BE RECRUITED RESULTING IN THE CLOSURE OF INPATIENT SURGERY.

PRIOR TO THE CLOSURE $700,000 HAD BEEN SPENT REMODELING THE SURGICAL SUITES AND PROVIDING FOR A SURGICAL RECOVERY UNIT.

IN NOVEMBER OF 1987, BECAUSE OF THE 4,000 SIGNATURE PETITION, ASKING THAT THE SURGICAL UNIT BE REOPENED, PRESCOTT VA MEDICAL CENTER WAS VISITED BY THOMAS HARVEY, ASSOCIATE ADMINISTRATOR OF THE VA. MR. HARVEY STATED THAT IN 1984 AND 1985 THERE WERE ONLY 600 SURGICAL PROCEEDURES PERFORMED AT THE PRESCOTT VA MEDICAL CENTER. DISABLED AMERICAN VETERANS HOSPITAL SERVICE OFFICER TIMOTHY BOYD IN CHECKING SURGICAL PROCEEDURES FOR THE APORE MENTIONED YEARS FOUND THAT IN 1984 THERE WERE 2013 SURGICAL PROCEEDURES PERFORMED. IN 1985 THERE WERE 1660 SURGICAL PROCEEDURES PERFORMED. IN FISCIAL YEAR 1986, THE ONE REMAINING SURGEON PERFORMED 659 OUT-PATIENT SURGICAL PROCEEDURES, AND IN EXCESS OF 500 PATIENTS WERE REFERRED TO THE PHOENIX AND TUCSON VA MEDICAL CENTERS AND LOCALLY TO THE YAVAPAI REGIONAL HOSPITAL.

THE DISCREPENCIES BETWEEN MR. HARVEY'S FIGURES AND MR. BOYD'S FIGURES WERE TO BE RESOLVED BY A VA ASSESMENT TEAM. THIS ASSESMENT TEAM WAS TO REPORT TO VA HEADQUARTERS IN WASHINGTON, DC. WE HAVE YET TO BE TOLD THE RESULTS OF THE TEAMS ASSESMENT.

DUE TO THE TREMENDOUS GROWTH IN THE OLDER VETERANS POPULATION IN ARIZONA THE NEED FOR SURGICAL PROCEEDURES WILL CONTINUE TO GROW. FOR TWO ARIZONA VA MEDICAL CENTERS TO HANDLE THE SURGICAL LOAD OF THE THREE VA MEDICAL CENTERS MEANS LONGER WAITING PERIODS BETWEEN DIAGNOSIS OF SURGICAL NEEDS AND THE ACTUAL SCHEDULING OF OPERATING TIMES. SOMETIMES THIS WAITING PERIOD EXCEEDS 3 MONTHS. TIME IN WHICH THE VETERAN COULD SUCCUMB TO HIS AILMENT.

FOR A RESIDENT OF THE FAR NORTHWESTERN OR NORTHEASTERN SECTION OF ARIZONA, NORMALLY SURGICALLY SERVICED BY THE PRESCOTT VA MEDICAL CENTER, TO BE FORCED TO TRAVEL AS MUCH AS

800 MILES ROUND TRIP FOR THEIR SURGICAL NEEDS MEANS THEY ARE SUBJECTED TO A PAINFULLY LONG TRIP FOR ONE WHO IS ILL, A LOSS OF FAMILY SUPPORT DURING HOSPITALIZATION AND OFTEN AN UNNEEDED FINANCIAL BURDEN TO THE FAMILY IF IT DOES TRAVEL TO VISIT DURING THE VETERANS RECOVERY.

WE REALIZE THAT CERTAIN SURGICAL PROCEEDURES, SUCH AS HEART BY PASS, VASCULAR SURGERY, AND MAJOR ORTHOPEDIC SURGURY MUST STILL BE PERFORMED IN THE PHOENIX AND TUCSON VA MEDICAL CENTERS BECAUSE OF THEIR AFFILIATION WITH THE UNIVERSITIES.

I FEEL THAT WITH THE NEW 60 BED NURSING HOME UNIT UNDER CONSTRUCTION AT PRESCOTT VA MEDICAL CENTER, THE NEW 200 BED DOMICILIARY UNIT TO BE CONSTUCTED REPLACING THE OLD OUTDATED DOMICILIARIES, AND THE EXISTING 200 BED HOSPITAL THERE IS A DEFINITE NEED FOR AN INPATIENT SURGICAL UNIT IN THE PRESCOTT VA MEDICAL CENTER.

THANK YOU FOR YOUR CONCERN FOR THE ARIZONA VETERAN POPULATION AND THEIR NEEDS.

Raymond A. Pelkey

STATEMENT OF LENCHO OTHON, COMMANDER
DEPARTMENT OF ARIZONA
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
05 JULY 1988

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to share with you its views on the accessibility of Arizona veterans to Veterans' Administration health care. The general area to be studied is the Department of Medicine and Surgery; comment will be on specific categories as herewith mentioned.

*1. Overall issue of allocation of health-care resources to VA facilities in Arizona: At the outset Mr. Chairman, we feel it necessary to reiterate The American Legion's long-standing philosophy on the funding of veterans benefits and programs. This organization has a total commitment to the health and well-being of this state's veterans, and therefore, stands for full funding for veterans programs. By that we mean there should be provision of such funds as are necessary to effectively carry out the programs that have been established by Congress. We support all of those needed programs. Each of them had a purpose when enacted, and each has been proven as currently meeting a legitimate need of the veteran population. We are aware of no programs at present that are superfluous or redundant.

However, we must again put forth our objection to the continuation of the Means Test and Third Party Reimbursement (Public Law 99-272). Through survey visits to VA medical centers by our Washington, D.C. office it has consistently been found that the Means Test appears to be more costly to administer than profitable to maintain. The rate of Means Test collections to billings is far less than initial VA projections. Furthermore, VA's own Means Test data has conclusively shown Category C veterans average less that three percent (3%) of the systemwide workload. The cost factor to maintain this program far exceeds revenue realized by the U.S. Treasury. The Means Test and Third Party Reimbursement programs have changed the nature of the VA health care program by making it a cost-sharing program rather than a benefit program as intended by the American public. Resolutions emanating from the 1987 American Legion National Convention support continued opposition to the Means Test and Third Party Reimbursement.

It is contended that by eliminating the Means Test and Third Party Reimbursement more funding could be applied to those needed viable health programs lacking proper funding.

*2. The availability of surgical services for veterans residing in the Prescott area: It is positively conceded that appropriate surgery service is of utmost concern to The American Legion to our veteran population in northern Arizona. However, of primary import is the formulation of a concrete mission statement for VA Medical Center, Prescott.

If there is not a firm foundation for surgery and a well grounded financial commitment for proper staffing then success will not be had. Just to have a surgical unit for convenience sake without proper resources may lead to an increase in claims under 38 United States Code § 351 and Federal Tort Claims Act. This would be unfortunate and defeat the purpose for which VA Medical Center in Prescott, AZ was established.

Secondly, it is hoped that with the enactment of Public Law 100-322, problems unique to the residential areas of Northern Arizona's veteran population will be rectified regarding surgery needs. There is a two (2) year pilot program using mobile health clinics for eligible veterans residing at least 100 miles from the nearest medical facility. In conjunction with this new aid, from our understanding, there are fee-basis referrals to the private medical facilities in addition to transfer to other VA Medical Centers.

*3. The availability and quality of counseling and psychiatric services for Vietnam veterans through the Vet Centers in Arizona; the inpatient PTSD unit at the Phoenix VAMC, and otherwise: The American Legion supports continuation of the Vet Center Program, contingent on a plan wherein decisions on assimilating the Readjustment Counseling Program into the VA Medical Centers, will be made on a case by case basis, as the utilization of services diminishes. The nationwide and statewide workload totals for the Vet Center Program in FY 1987 show the highest levels for new veteran clients and total cumulative visits since the inception of the program. Therefore, we adamantly oppose the idea of reducing the funding or the employment level.

*4. Issues relating to the recruitment and retention of nurses at VA facilities in Arizona and the adequacy of current nurse staffing levels at those facilities: We are pleased to note, per Public Law 100-322, that more attention is being given to the retention of Nurses within VA Medical Centers. Specifically, authorizing incentive bonuses, tuition reimbursement and premium pay for Registered Nurses (R.N.) who work on Saturdays.

In addition requiring the Chief of Nursing Service at each VA Medical Center be included in each policy making committee at that facility. This, we feel, is a positive step in recruiting and retaining this needed personnel resource.

*5. The access of Arizona veterans to nursing home care, either at VA facilities or at VA expense: A problem we have run into is that when a worthy and needy veteran is found to be a candidate for Nursing Home Contract through a VA Medical Center funding is lacking. This could either be on the initial contract or when the family has not yet found a suitable plan of action for placement. Of course this is moot if the condition is service-connected in nature and placement is provided for.

We realize that there are forthcoming plans to alleviate this concern by way of the Indian School land; however, we do not know exactly how long this will take. In the meantime there is a gnawing need from our aging veteran population to resolve this issue. A case in point is found within the attached letter addressing the Payson, AZ region under the jurisdiction of Carl T. Hayden VA Medical Center, Phoenix, AZ.

This unfortunate situation has also been noted on occasion in the V.A. Medical Center, Prescott, AZ area. We believe by inquiring to the Social Work Service there, it would be revealing as to the need associated with our aging veteran.

Mr. Chairman, that concludes our statement and thank you again for this opportunity.

Medical Center

Seventh Street and Indian
School Road
Phoenix, AZ 85012

Veterans
Administration

May 10, 1988

In Reply Refer To 644/90C

Mr. Art Brest
The American Legion
3225 North Central Avenue
Phoenix, AZ 85012

Dear Mr. Brest:

In response to your recent letter inquiring as to the position of this Medical Center in regards to a nursing home contract in Payson, Arizona. Our office has responded to requests for nursing home services with Manzanita Manor, Payson, Arizona in August 1986 and again in February 1987. In October 1987 a response to an inquiry from Senator DeConcini was sent out over the signature of the Medical Center Director.

The following is an excerpt of that letter:

"Our position and ability to maintain a nursing home contract in the Payson area remain unchanged. This Medical Center currently maintains 34 contracts with 19 facilities in the valley area; as far west as Sun City and Apache Junction to the east. The current census of veteran placements as of this date is 133. Regulations require monthly visits and, in the event problems exist, the nursing home is monitored closely with more frequent visits required. The staff available to follow existing contracts is limited and their schedules continue to be satiated."

It is an important concern of this Medical Center to provide our veterans with the best care available. We regret that all requests for nursing home contracts cannot receive a positive response and we appreciate your concern and inquiry regarding the provision of care to our veterans. Please feel free to contact me if I can be of further assistance.

Sincerely,

Jan Litchfield

JAN LITCHFIELD
Contracting Officer

VETERANS OF FOREIGN WARS OF THE UNITED STATES
DEPARTMENT OF ARIZONA — 6807 E. THOMAS RD., SCOTTSDALE, AZ 85251
TELEPHONE 941-5258

STATEMENT OF

DONALD E. MAYNARD
DEPARTMENT COMMANDER
VETERANS OF FOREIGN WARS OF ARIZONA

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
WITH RESPECT TO

ACCESS OF ARIZONA VETERANS TO VETERANS'
ADMINISTRATION HEALTH CARE

PHOENIX, ARIZONA JULY 5,1988

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the over 30,000 members of the Veterans of Foreign Wars of Arizona and its Ladies Auxiliary, I wish to thank the memebers of the Committee for including us in this forum here today, which will address the access of Arizona veterans to Veterans' Administration health care. It is, as always, both a pleasure and a privilege to take part in an effort to improve a program which has been so profoundly beneficial to the nation and this nation's military veterans. The Department of Arizona VFW remain firmly committed to working for the improvement of these invaluable veteran's program.

First to be addressed today is the overall issue of allocation of health care resources to VA facilities in Arizona. In our view, the VFW is on record as supporting increasing resources for the health care allocations to VA facilities in Arizona as this is one of the largest growing retirement states in the United States and each year we get more and more "Snow Birds" during

the winter months, which in turn taxes our VA health care facilities, which in turn lets the VAMC's get more resources sooner and faster if Central office (VACO) has the funds. We would suggest that VACO program funds for this purpose in the future. The Georgraphic Distribution of VA expenditures for FY 1987 for Medical Services and Administration costs for the three Medical Centers in Arizona was $157,553,923 dollars with $76,153,517 dollars going to Phoenix VAMC, $59,736,889 dollars going to Tucson and the remaining $21,663,517 dollars going to Prescott. The construction and related costs to these three facilities was $2,482,394. This Department would support any increased funding that these three facilities directors may request.

The second issue to be addressed today is that of "the availability of surgical services for veterans residing in the Prescott area." The Department of Arizona cannot support reopening of the surgical ward at the Prescott VAMC. At the present time all surgery from or within the Prescott veterans area is done by Phoenix VAMC or Tucson VAMC and I do not see at this time or in the future that the need will change for this unit to be reopened at Prescott. The veterans from that area that require surgery are handled on the needs, just like veterans from the Tucson area and the Phoenix area, routine are scheduled as opening occur, priority and emergency surgery is normally scheduled the following day. This Department has received no complaints reference surgical availability in the Prescott area.

The third issue today is "the availability and quality of counseling and psychiatric services for Vietnam Veterans through the Vet Center in Arizona, the Inpatient PTSD Unit at the Phoenix VAMC." The Inpatient PTSD Unit at the Phoenix VAMC is doing an exceptional job. The availability and quality of counseling and psychiatric services at the Vet Center is pretty good, they have high quality counselors.

but the availability is lacking in that there is a waiting list due to a staff of 4 (four) which not all are counselors, there is no outreach programs and there are many vets out there that need this service, the Center works close with mental health and the Inpatient PTSD program and the VFW feels that the psychiatric service is really good at this center. The VFW would support any request for more staff and an outreach program.

Fourth issue "relating to the recruitment and retention of nurses at VA facilities in Arizona and the adequacy of current nurse staffing levels at these facilities." The Veterans Benefits and Services Act of 1988 (Public Law 100-322) signed by the President on May 20, 1988, authorizes incentive bonuses for registered nurses as recruitment tools and may provide up to $4,000.00 per year for a four year employment agreement, provides authority to pay premium pay to registered nurses working Saturdays, authorizes tuition reimbursement for registered nurses, requires the Chief of Nursing Services at each VAMC facility be included in each policy making committee at that facility, this is a great bill overall, but it isn't doing much for the VAMC's here in Arizona, recruitment and retention here is bad due to the VAMC's being unable to compete with salary range with the private sector, if the VAMC's offer $2.00 more, the private sector offers $4.00 more. As far as the staffing levels are concerned I think Medical Director Ray Bourne is better qualified to speak on this issue, but from my observation and visits throughout the Medical Centers the nurses on duty are doing an outstanding job with the present staffing levels and the VFW does realize there are shortage in the VAMC's and that recruitment is ongoing daily to try to fill nursing positions. The VFW would support any special programs that VA could come up with to get the recruitment and retention of nurses here in Arizona.

The last issue of "the access of Arizona veterans to nursing home care, either at VA facilities or at VA expenses."

The VFW has worked many nursing home claims/cases here in Arizona and has found that the access of Veterans to either VA facilities or Community Nursing Homes has been outstanding by the Medical Centers concerned. At the present some VAMC's here in Arizona have used up all alloted funds for present Community Nursing Home placement, but are working very hard to satify any requirement for community nursing home placement that is occuring, the nursing home care unit at the Phoenix VAMC is being used at the average of 118 bed strength with 120 bed capacity and with the online construction of the 120 bed VA Nursing Home at the Tucson VAMC with projected construction start date of November 1988 the VFW feels that with the long term care at the Prescott VAMC and if the ongoing contract Community Nursing Home monies comes thru and using maximum bed capacity at the Phx VAMC Nursing home unit and when the 120 bed nursing home unit comes on line at Tucson VAMC then Arizona would be in pretty good shape with accesibility to Nursing Home care either at VA facilities or at VA expense.

Mr. Chairman and members of the Committee this concludes my statement and I will be happy at this time to answer any questions you may have. Thank You.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

September 12, 1988

COPY

John A. Gronvall, M.D.
Chief Medical Director (10)
Department of Medicine & Surgery
Veterans Administration
810 Vermont Avenue, N.W.
Washington, DC 20420

Dear Doctor Gronvall:

I am forwarding herewith a copy of report of survey of the Prescott, Arizona, Veterans Administration Medical Center, conducted by Mr. Robert F. O'Toole, Senior Field Representative, of our staff.

You are advised that the Medical Center Director is being furnished a copy of this report.

A response at your convenience will be appreciated.

Sincerely,

Cooper T. Holt

COOPER T. HOLT
Executive Director

Enclosures

★ WASHINGTON OFFICE ★
VFW MEMORIAL BUILDING ● 200 MARYLAND AVENUE, N.E. ● WASHINGTON, D. C. 20002 · 5799 ● AREA CODE 202 543-2239

VETERANS OF FOREIGN WARS OF THE UNITED STATES
National Veterans Service
REPORT OF SURVEY OF VETERANS ADMINISTRATION MEDICAL CENTER

STATISTICAL SHEET

DATE 6/27/88

LOCATION Prescott, Arizona

CLASSIFICATION VA Medical Center

MEDICAL SCHOOL AFFILIATION None

DIRECTOR Alfonso Estrada, Jr.

CHIEF OF STAFF F. C. Lepperd, M.D.

AUTHORIZED BED CAPACITY Hosp 217 (Dom 214)

OPERATING BEDS Hosp 193 (Dom 214)
OUT OF SERVICE Hosp 24; Dom 0

PLANNED ADC, CURRENT FY Hosp 116.0 (Dom 196)

CUMULATIVE ADC TO DATE Hosp 103.9 (Dom 192)

CUMULATIVE ADC, ONE YEAR AGO Hosp 112 (Dom 196)

TOTAL PATIENTS TREATED (CUMULATIVE):
INPATIENT LAST FY Hosp 3219 (Dom 522)
INPATIENT TO DATE CURRENT FY (May) Hosp 2356 (Dom 392)
NON-VETERAN PATIENTS TREATED FY TO DATE 0

BED OCCUPANCY RATE (CUMULATIVE) (thru May) 66.7

PATIENT TURNOVER (CUMULATIVE) 262

AVERAGE LENGTH PATIENT STAY 11.1

APPLICATIONS PENDING 0

NSC WAITING LIST (CURRENT) 0
(ONE YEAR AGO) 0

SCHEDULED FOR ADMISSION 0

ACCEPTANCE RATE (CUMULATIVE) 100%

VETERAN POPULATION AREA OF JURISDICTION

FULL-TIME EMPLOYEE EQUIVALENT 455.5
TOTAL ON BOARD 446.4

STAFF PHYSICIANS 20

PART-TIME PHYSICIANS 5

CONSULTANTS 35
CONSULTANTS VISITS LAST QTR 80 onsite
43 offsite

DENTISTS 3

RESIDENTS None

REGISTERED NURSES 84

LICENSED PRACTICAL NURSES 20

NURSING ASSISTANTS 6

PART-TIME RN'S 5 LPN'S 1 NA'S 1

BUILDING MANAGEMENT EMPLOYEES 28 1

ADMINISTRATIVE EMPLOYEES 105.9

STAFFING RATIO (SPECIFY CORE, ETC.):
CURRENT FY .73
PREVIOUS FY .69

TOTAL OPERATING BUDGET:
CURRENT FY $ 21,556,700
PREVIOUS FY $ 21,417,869

RESEARCH BUDGET:
CURRENT FY $ 0
PREVIOUS FY $ 0

MAJOR CONSTRUCTION:
FUNDED CURRENT FY $ 16,600,000

COST PER PATIENT DAY $ 174.03 (Direct)
257.73 (Total)

OUTPATIENT CLINIC

STAFF VISITS:
FY TO DATE 51321
FUNDED FOR FY (unclear)
PREVIOUS FY 72903
FUNDED FOR PREVIOUS FY (unclear)

PATIENTS UNDER DATE:
OPT-SC 37%
OPT-NSC 63%
C&P EXAMS FY TO DATE 127
PREVIOUS FY 246

INCLUDE STATISTICS FOR DOMICILIARY AND NURSING HOME CARE UNIT (NHCU) WHERE APPLICABLE.

VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL VETERANS SERVICE
REPORT OF SURVEY OF VETERANS ADMINISTRATION MEDICAL CENTER
PRESCOTT, ARIZONA

July 25-28, 1988

1. INTRODUCTORY REMARKS:

By order of Brigadier General James H. Carleton, commanding the military district of Santa Fe, Fort Whipple was established in 1863, to protect the gold fields of Northern Arizona in the Chino Valley. The fact the Fort was established on the wrong site appears to have had no effect since the post has survived to the present. As with most frontier army posts, Ft. Whipple was allowed to fall into a deteriorated state at various times only to be reactivated and rebuilt. Captain "Bucky" O'Neill, during the war with Spain, originated a part of the "rough riders" from volunteers at this post. He was later killed during the charge up San Juan Hill.

General Arthur MacArthur reopened the post in 1902 for a short time. Then during the World War, the Fort came into its own by being reactivated as an Army Hospital to treat tuberculosis due to its location in the Central Arizona mountains. The hospital was later transferred to the U.S. Public Health Service, Veterans Bureau, and then to the Veterans Administration. The post has had a long and sometimes stormy history, but has been able to survive by adapting to the needs. Once again, the medical center is being asked to adapt to a changing role. Not all changes, however, are always beneficial to the ones served. Hopefully, this will be pointed out in this report.

2. DIRECTOR AND CHIEF OF STAFF:

The medical center is authorized 217 beds in the hospital plus a 214-bed Domiciliary for a total bed capacity of 431. Currently, only 350 beds are open. Medicine has 30 beds closed for ward renovation, Surgical Service has 27 beds closed due to a mission change, Rehabilitative Medicine has 10 beds closed due to ward renovation and the Domiciliary has 14 beds closed due to patient privacy and safety standards. Of these, all but the 14 beds in the Domiciliary are available to be reopened.

The operating budget for FY 88 is $21,556,700 which is about $140,000 above last fiscal year. This did not, however, keep pace with inflation. Expectations for FY 89 are for a decrease in funding. Due to slack management by the former Director, this medical center was allowed to slip into a downward spiral, which will take a lot of effort and cooperation on the entire staffs' part to correct. The new Director has entered into the challenge by creating eight task forces to look at every aspect of the hospital. As with all changes, one can see apprehension, but more excitement is taking over as the staff sees the object of the task assigned.

The hospital has been grouped with Phoenix and Tucson for shared services. The Prescott Medical Center has a need for 50 CT scans per month. However, Phoenix can only provide 8 or less per month. This leaves the patients at Prescott without the services of this important diagnostic procedure since the center does not have the funds to contract for this service. For this reason, as well as those which will be pointed out under the paragraph entitled Medical Service, this medical center should have their own CT scan. The veterans of northern Arizona deserve the same top quality health care as southern Arizona veterans. Arizona, being in the Sunbelt, has one of the fastest growing populations in the nation. The Phoenix area is increasing at the highest rate in the state. There is no way the Phoenix Medical Center can take care of the needs of the veterans of the northern part of the state in addition to their own assigned veterans.

3. MEDICAL ADMINISTRATION SERVICE (MAS):

This service has a ceiling of 55 with 5 vacancies. The medical center acceptance rate is 98 percent. The medical center's veteran population is divided up by 90 percent being Category A, 4.4 percent being Category B and the remaining being in Category C or unknown. The MAS clerks need to be provided additional training and closer supervision to assure that proper credit is being received for the accomplished work load. The correct coding and accounting for the patients is very important. This area could be the reason the hospital is suffering under the Resource Allocation Methodology Model.

The quarterly processing time study conducted during the third quarter of FY 88, shows that the veterans are receiving prompt service. During normal hours, the processing time is 1 hour and 52 minutes. During irregular hours the processing time is 2 hours and 35 minutes. The hospital discharge summaries are being completed on time by the physicians, but are being held up in transcription. Currently, there are 100 reports waiting to be typed. During FY 87, the hospital had 115 patients expire with 29 autopsies being conducted for a 25.2 percent average. This is only half of the VA standard.

4. MEDICAL SERVICE:

This service has 11 doctors assigned full-time, which included the Chief. In spite of the relative isolation of the hospital, this medical center has some well qualified physicians, with all but one new doctor being certified by their specialty boards. The new doctor is qualified and will be taking his exams.

A meeting was held with all the Medical Service physicians to receive their views on the change of mission of the medical center. It was the general consensus that the practice of medicine at this medical center had been set back fifty years without the availability of surgery. The non-availability of surgical consultants to become involved early in the case, causes many concerns with the physicians. The doctors cannot transfer a patient to Phoenix without calling first, which causes delays in treatment. The surgeons at Phoenix are rarely available in the

mornings to receive calls from the physicians, since they are normally in surgery. This means a delay until late afternoon or evening before the patient can be transported. In the winter, transporting can require a snow plow to open the road, police escorts (both state and county) and the hospital van just to get down from the mountain to where the helicopter can pick up the patient. Last winter, this procedure took over 6 hours to get a patient to the helicopter. One must ask, is this modern medicine being provided by a grateful nation to our veterans? Patients are being returned from Phoenix to be followed by the Prescott medical staff as early as the second post surgical day.

Many of the medical test and procedures cannot be conducted without surgical back-up such as biopsy and endoscopies. Older veterans who make up the majority of the hospital patients are chronically ill and have multiple illnesses. This requires a multidisciplinary approach to their care, which includes surgery. To send these veterans to Phoenix requires the Prescott medical staff to conduct various tests to determine the need for the procedure, a ride of 100 plus miles in a van which is crowded and hot, a change in altitude from 5,000 feet above sea level down to the valley floor where the temperatures are commonly over 110 degrees, all while sick and then they must face going through the same medical test all over since no doctor is going to operate using someone else's findings. The ride back as early as two days post operation cannot be any better.

The lack of surgical back-up also has a serious impact on the intensive care unit as well as the respiratory technicians and nurses. Decisions by the health care provider can be adversly affected when they know that if anything goes wrong, there is no Surgical Service back-up.

The days of practicing medicine out of a small black bag and a buggy in America are gone. Physicians today are trained in modern facilities with all services on-site. To properly practice acute medicine in a remote area there must be surgery available. Northern Arizona, with a few isolated exceptions, is a medically underserved area. The decision to close surgery at this medical center was made, not on a medical basis, but from a financial standpoint and without the best interest of the veteran in mind.

5. SURGICAL SERVICE:

A hearing was held on July 5, 1988, by Senator Dennis DeConcini for the Senate Veterans Affairs Committee, on the closing of the Surgical Service at this medical center. According to information received, testimony was given that this service had only performed 35 to 55 surgical procedures a year for the last 6 years. A question was asked by Senator DeConcini, if these figures were confirmed with the Chief of Surgery at Prescott. The answer was no, there was no need to, the figures came from the computer. If one does not ask a computer the proper question, an improper answer will appear. This may be the case because the annual reports from the Surgical Service for the last 10 years reveals that the number of operations far exceed the number given at the hearing for every year.

The following chart shows the number of procedures done during the last ten years:

FY YEAR	MAJOR	MINOR	DIAGNOSTIC PROCEDURES	TOTAL
1978	527	421	555	1,503
1979	474	468	544	1,486
1980	478	473	521	1,472
1981	439	409	477	1,325
1982	366	418	233	1,017
1983	364	365	250	979
1984	444	314	407	1,165
1985	340	329	454	1,123
1986	227	306	713	1,246
1987	10	607	424	1,041

This chart does not include the number of therapeutic surgical procedures, the anesthesia administered or the number of consultants who treated patients. This type of work load cannot be handled by the one surgeon remaining or by the Phoenix Medical Center when considering their already heavy and growing work load.

The service has three operating rooms, a three-bed recovery room, an endoscopy room and a urology room. Ward space is available to be utilized for surgical patients. It is highly recommended that the Surgical Service be reopened at this medical center and that it be allowed to care for the veterans of northern Arizona properly.

6. NURSING SERVICE:

Current FTEE 125. They have 115.5 on board with 88.4 being registered nurses, 28.6 LPNs and 4.5 nursing assistants. A total of 20 nursing students rotate through the medical center during the year. The turnover rate is 22 percent with no recruiting problems reported. The hospital is considered to be well set up for patient safety. However, from a treatment standpoint, the center is lacking in both gases and suction capabilities at most of the bedsides. Currently, portable equipment must be utilized which can be hazardous. A project is in the five year plan to renovate the wards to include this capability.

7. RADIOLOGY SERVICE:

This service has a total of five rooms. There are four radiography rooms and one ultrasound room. Of these, three of the radiography rooms need to be replaced with new equipment. The head unit is over 25 years old. The tomographic unit is now due for replacement as it has reached its life expectancy and the radiographic/fluoroscopy room reached this point over three years ago. The total cost, along with the required remodeling, would be $650,000.

8. PHARMACY SERVICE:

FTEE 16 with 2 vacancies. Staffing would be considered adequate if vacancies were filled. The station instituted full unit dose during 1983-84. They filled 121,057 prescriptions last fiscal year with 75 percent being mailed. The work load is expected to increase by 23,000 prescriptions this year. Turnaround time is within 48 hours for mailout prescriptions. The window waiting time studies are conducted monthly and indicate prescriptions are being delivered to the patient within 30 minutes.

The pharmacy administered 396,991 patient doses last year with a slight decrease expected this year. The current pharmacy space is inadequate. There is a shortage of between 500 and 1,000 square feet for storage, 150 square feet in unit dose cart exchange area and about 50 square feet needed for a patient counseling area.

9. ENGINEERING SERVICE:

This service has 39 FTEE with 2 temporary employees and 2 summer aides. They are also responsible for the maintenance at the National Cemetery (closed to new internments), which is located across the highway from the medical center.

The station is located inside the jurisdiction of the Prescott City Fire Department. Therefore, fire protection is furnished by that agency. It takes about 3 - 5 minutes for the fire trucks to arrive following an alarm.

It has becomes quite apparent that two painters cannot keep up with the five year paint schedule. Additional painters will have to be employed during the year to keep up the appearance.

Future plans call for a replacement 208-bed Domiciliary and a 60-bed Nursing Home Care Unit (NHCU) to be constructed during the near future. The NHCU now has the structure steel in place. It is designed so that an additional 60-bed unit can be constructed on top of the structure. However, if this is accomplished, the engineering equipment being used for the 60-bed unit will have to be replaced, or additional units added, to handle 120 beds. A new library building was dedicated during my survey. A clinical expansion project is scheduled for 1990 which will relieve many of the space problems in Ambulatory Care and Pharmacy.

10. REHABILITATION MEDICINE SERVICE:

This is another service that is directly effected by the lack of Surgical Service. Many of the patients seen by this service are post-operative from Phoenix or must be shipped to that facility for care not now available in Prescott. The service has 2 part-time physicians and 4 therapists (2.5 physical, 1 occupational and 1 manual arts) along with a half-time speech therapist and 2 physical therapy aides. The vocational rehabilitation specialist and the case manager are both registered nurses.

Prosthetics is a big problem at this medical center. A MAS clerk is assigned collateral duties as the prosthetics clerk, but the funding for this activity is controlled from Phoenix where there has been complaints received of veterans having trouble getting limbs and supplies due to budget reductions.

11. SOCIAL WORK SERVICE:

FTEE 8.5 with 6 being social workers. There are no vacancies. Central Office staffing guidelines calls for 19 FTEE for medical centers the size of Prescott. This service is spread so thin that a number of services complained about the lack of social work support. The Residential Home Care program was closed due to staffing. Only six Nursing Homes are currently under contract. The cost ranges from $62 to $84.50 per day with the average running $74.32.

The alcohol treatment program halfway house program has been reduced from 60 days to 14 days due to funding; although regulations permit 60 days, or with extenuating circumstances a 90-day stay.

The Domiciliary has one social worker when they should have 5 on duty. The blind and spinal cord injury veterans in this medical center's primary service are not visited due to staffing limitations.

12. VOLUNTARY SERVICE:

There are 26 organizations certified to this medical center's advisory committee. They have 325 regularly scheduled (RS) volunteers who have given 39,170 hours during the first 9 months. The VFW has 34 RS volunteers with 5,425 hours for the same period. The Chief has one assistant who is classified as a program clerk. Public relations is also handled by this service. The unobligated general post fund has $20,535 in the account from donations. The biggest problem facing this service is securing donations.

13. DIETETIC SERVICE:

FTEE 45.56 with 4 dietitians and 1 diet technician. At this time, no patients or Domiciliary residents are used as workers. They could, however, utilize one or two incentive therapy patients in the kitchen.

The dining hall is used by the Domiciliary and those inpatients able to ambulate. They serve about 450 meals in the dining hall figuring in a 81 percent dom factor. About 10 outpatients and 25-30 volunteers receive meals per week. They modify about 52 percent of the meals and use about 30 percent convenience items. The raw ration cost is $3.36 (2nd quarter) and $3.79 (3rd quarter). The kitchen equipment is reaching its life expectancy and will have to be replaced shortly.

14. WOMEN VETERAN COORDINATOR:

Kim Radant, Acting Chief Nurse, was appointed to the position as Women Veteran Coordinator in April, at the time the former Chief transferred. She is attempting to hold down the position while management looks for a female veteran to fill the position. The medical center needs to form a committee to assist the Coordinator in instituting an outreach program and in designing a local pamphlet on services available to women in Prescott. For an old facility, the medical center has adapted to the needs of the females very well. The Womens Marine League provides assistance to female patients to assure that their needs are met.

15. DOMICILIARY OPERATIONS:

This is a very active Domiciliary since it is located in an ideal area of the Sunbelt. The staff consisting of a Chief, Assistant Chief, secretary and five health technicians averages 1.5 applications per day. The buildings were built in 1903 (3) and 1920 (1), and are showing their age, but have been well maintained. After 85 years, the VA is going to construct a replacement 208-bed Domiciliary building which will place all the residents in one building with all necessary support facilities.

To meet the needs of the majority of the veterans applying for admission, the center needs to institute a more intensive alcohol program. Program development should include treatment planning, individual counseling and the services of an additional psychiatric nurse to implement the program.

16. FINDINGS AND RECOMMENDATIONS:

a. The medical center cannot provide quality health care to veterans in northern Arizona without a Surgical Service. The facts do not support the closing of this service. The VFW supports the reopening of surgery as soon as possible.

b. Due to space deficiencies in Ambulatory Care and Pharmacy, the clinical addition in the five year plan scheduled for FY 90, should not be put off. The space utilized for Ambulatory Care was designed to service 15,000 patient visits annually. They are now exceeding 70,000 patient visits.

c. Most of the beds in the wards do not have piped in gases or suction capabilities. This should be corrected as soon as possible due to the hazard of moving portable equipment and the time delay in providing the care.

d. Closer supervision of the clerks in Medical Administration should be given along with training to assure that proper credit is being received for work accomplished.

e. The backlog in transcription should be reduced to a more acceptable level.

f. The alternative of a Residential Home should be available to veterans in this primary service area. We recommend that the program be restarted on a small scale until the need for additional staffing in Social Work Service is filled.

g. An active community care program should be started. This would assist in bringing new veterans into the medical center.

h. Much of the radioscopy equipment has exceeded its life expectancy. This equipment should be replaced following the plans and schedule submitted by the medical center to Central Office.

i. Rural areas in northern Arizona are medically underserved and lack adequate public transportation. Prescott has one bus per day in and out. No trains or planes are available.

j. Locally produced pamphlets on services available for women veterans should be designed and made up for use of the Women Veteran Coordinator's outreach program. An active outreach program should be set up.

k. A C mittee to assist the Women Veteran Coordinator should be set up using representatives from each service that is involved in the care or treatment of women veterans.

17. EXIT INTERVIEW:

Since the Director has only been on board for about one month, he was acutely interested in the observation of the VFW of the medical center and the job they were accomplishing. Key staff members were invited to sit in during the meeting. All of the findings and recommendations appended to this report plus others that were only vocalized were discussed in detail. While no position was stated by the Director to the reopening of surgery, it was obvious that they would be ready if the decision was made by Central Office. The Director was requested to pass on to his staff my appreciation for the assistance provided by them which made my visit more enjoyable.

ROBERT F. O'TOOLE
Senior Field Representative
National Veterans Service

RFO/gal